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DEPARTMENT OF PUBLICE WELFARE

MEDICAL ASSISTANCE PROGRAM

PHYSICIAN SERVICES **********

THE COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE .....

106 CMR is amended by repealing 106 CMR 451.000: Physician's Services, and by striking out all of the sections contained in 106 CMR 433.000: Medical Assistance Program: Physician Services and inserting in their place the following sections:

106 CMR 433.000: MEDICAL ASSISTANCE PROGRAM: PHYSICIAN SERVICES

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PART 1. GENERAL INFORMATION

(106 CMR 433.001 through 433.400 Reserved)

433.401: Definitions

The following terms used in this Chapter 433.000 shall have the meanings given in this section unless the context clearly requires a different meaning.

(A) Adult Office Visit -- a medical visit by a recipient 21 years of age or older to a physician's office or to a hospital outpatient department, emergency room, or courtesy room.

(B) Consultant -- a licensed physician whose practice is limited to a specialty and whose written advice or opinion is requested by another physician or agency in the evaluation or treatment of a recipient's illness or disability.

(C) Consultation -- those services provided by a consultant. If the consultant assumes the continuing care of the recipient, any subsequent service provided by the consultant is no longer considered a consultation.

(D) Couple Therapy -- therapeutic services provided to a couple for whom the disruption of their marriage, family, or relationship is the primary reason for seeking treatment.

(E) Diagnostic Radiology Service -- a radiology service intended to identify an injury or illness.

(F) Domiciliary -- for use in the recipient's place of residence, including a long-term care facility.

(G) Emergency -- a sudden or unexpected illness or injury that must be treated promptly to prevent harm to the recipient.

(H) Emergency Admission Service -- a complete history and physical examination by a physician of a recipient admitted to a hospital in an emergency, when definitive care of the recipient is assumed subsequently by another physician on the day of admission.

(I) Family Planning -- any medically approved means, including diagnosis, treatment, and related counseling, that assists individuals of childbearing age, including sexually active minors, in determining the number and spacing of their children.

(J) Family Therapy -- a session for simultaneous treatment of two or more members of a family.

(K) Group Therapy -- application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

(L) High-Risk Newborn Care -- care of a full-term newborn with a critical medical condition or of a premature newborn requiring intensive care.

(M) Home or Nursing Home Visit -- a visit by a physician to a recipient at a residence, nursing home, extended care facility, or convalescent or rest home.

(N) Hospital Visit -- a bedside visit by a physician to a hospitalized recipient, except for routine preoperative and postoperative care.

(O) Hysterectomy -- a medical procedure or operation for the purpose of removing the uterus.

(P) Independent Procedure -- a procedure that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but that commands a separate fee when performed as a separate entity not immediately related to other services. Such a procedure is designated "I.P." in the service descriptions.

(Q) Individual Psychotherapy -- private therapeutic services provided to a recipient to lessen or resolve emotional problems, conflicts, and disturbances.

(R) Institutionalized Individual -- a recipient who is either
(1) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or
(2) confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

(S) Intensive Care Services -- the services of a physician other than the attending physician, provided for a continuous period of hours (rather than days), required for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy.

(T) Mentally Incompetent Individual -- a recipient who has been declared mentally incompetent for any purpose by a

federal, state, or local court of jurisdiction, unless the individual has been declared competent to consent to sterilization.

(U) Not Otherwise Classified -- a term used in the lists of service codes and descriptions for service codes that should be used when no other service code is appropriate for the service provided.

(V) Oxygen -- gaseous or liquid medical-grade oxygen that conforms to United States Pharmacopoeia Standards.

(W) Pediatric Office Visit -- a medical visit by a recipient under 21 years of age to a physician's office or to a hospital outpatient department, emergency room, or courtesy room.

(X) Profile (or Panel) Test -- any group of tests, whether performed manually, automatedly, or semi-automatedly, that is ordered for a specified recipient on a specified day and has at least one of the following characteristics:

(1) the group of tests is designated as a profile or panel by the physician performing the tests;
(2) the group of tests is one of the "other profiles" in the laboratory service codes and descriptions (see Subsection 433.601(B)(2));
(3) the group of tests contains three or more tests from List A of the profiles section of the laboratory service codes and descriptions (see Subsection 433.601(B)(1)), even though the group may also contain tests not found in List A; or
(4) the group of tests is performed by the physician at a usual and customary fee that is lower than the sum of that physician's usual and customary fees for the individual tests in that group.

(Y) Prolonged Detention -- constant attendance to a recipient in critical condition by the attending physician.

(Z) Referral -- the transfer of the total or specific care of a recipient from one physician to another. For the purposes of these regulations, a referral is not a consultation.

(AA) Respiratory Therapy Equipment -- a product that:

(1) is fabricated primarily and customarily for use in the domiciliary treatment of pulmonary insufficiencies for its therapeutic and remedial effect;
(2) is of proven quality and dependability; and
(3) conforms to all applicable federal and state product standards.

(BB) Routine Study -- a set of X rays of an extremity that includes two or more views taken at one sitting.

(CC) Sterilization -- any medical procedure, treatment, or operation performed to make an individual permanently incapable of reproducing.

(DD) Therapeutic Radiology Service -- a radiology service used to treat an injury or illness.

(EE) Trimester -- one of three three-month terms in a normal pregnancy. If the pregnancy has existed for less than 12 weeks, the pregnancy is in its first trimester. If the pregnancy has existed for 12 or more weeks but less than 24 weeks, the pregnancy is in its second trimester. If the pregnancy has existed for 24 or more weeks, the pregnancy is in its third trimester. For the purposes of these regulations, the elapsed period of gestation shall be calculated in accordance with regulations of the Massachusetts Department of Public Health currently or hereafter in force.

433.402: Eligible Recipients

(A) Medical Assistance Recipients. For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for physician services subject to the service limitations in these regulations.

(B) General Relief Recipients. For General Relief recipients (category of assistance 04), the Department pays for all but the following physician services subject to the service limitations in these regulations:

(1) services provided in a hospital, except for the provision of life-sustaining drugs;
(2) abortion services; and
(3) drugs, except life-sustaining drugs.

433.403: Provider Eligibility

(A) Participating Providers.

(1) The regulations in this Chapter 433.000 apply to medical, radiology, laboratory, anesthesia, and surgery services provided to recipients by physicians participating in the Medical Assistance Program as of the date of service. A physician must have a Medical Assistance provider number before a claim will be processed by the Department.

(2) To be eligible for payment, a physician must be physically present and actively involved in the treatment of the recipient. Time periods specified in the service descrip-

tions refer to the amount of time the physician himself spends with the recipient, except in the instances noted where the service can be performed under the direct supervision of the physician. For surgery, the physician must be scrubbed and must be present in the operating room during the major portion of an operation.

(B) In State. A physician who is licensed by the Massachusetts Board of Registration in Medicine and who meets the requirements in Subsection (A) above is eligible to participate in the Medical Assistance Program.

(C) Out of State. An out-of-state physician who is licensed to practice in his state, who has obtained a Massachusetts Medical Assistance provider number, and who meets the requirements of Subsection (A) above is eligible to participate in the Massachusetts Medical Assistance Program. The Department will pay an out-of-state physician for providing reimbursable services to a Massachusetts recipient only under the following circumstances.

(1) The physician practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a recipient who resides in a Massachusetts community near the border of that physician's state.

(2) The physician provides services to a recipient who is authorized to reside out of state by the Massachusetts Department of Social Services.

(3) The physician practices outside a 50-mile radius of the border of Massachusetts and provides emergency services to a recipient.

(4) The physician practices outside a 50-mile radius of the border of Massachusetts and obtains prior authorization from the Department before providing a nonemergency medical service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the recipient significantly. To request prior authorization, the out-of-state physician or the referring physician must send to the Department a letter detailing the proposed treatment and naming the treatment facility (see the instructions for requesting prior authorization in Subchapter 5 of the Physician Manual). The Department will send copies of its decision to the recipient, the recipient's Welfare Service Office, the physician, and the proposed treatment facility. If the request is approved, the Department will assist in any arrangements needed for transportation and assistance payments.

433.404: Nonreimbursable Circumstances

(A) The Department will not pay a physician for services provided under any of the following circumstances.

(1) The services were furnished by a physician whose contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to recipient care.

(2) The services were furnished by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the recipient's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.

(3) The services were furnished by a physician who is a salaried intern, resident, fellow, or house officer. This regulation does not apply to a salaried physician when he supplements his income by providing services during off-duty hours on premises other than those of the institution that pays him a salary, or through which he rotates as part of his training.

(4) The services were provided in a state institution by a state-employed physician or physician consultant.

(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The Department will not pay a physician for performing experimental or unproven procedures.

433.405: Maximum Allowable Fees

The Massachusetts Rate Setting Commission determines the maximum allowable fees for medical, radiology, laboratory, anesthesia, and surgery services. Payment is always subject to the conditions, exclusions, and limitations set forth in this Chapter 433.000. Payment for a service shall be the lowest of the following:

(A) the physician's usual and customary fee;

(B) the physician's actual charge submitted; or

(C) the maximum allowable fee listed in the applicable Rate Setting Commission fee schedule, subject to any fee reductions

enacted into law. The Rate Setting Commission fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:

114.3 CMR 16.00: Surgery and Related Anesthesia Care
114.3 CMR 17.00: Medical and Related Anesthesia Care
114.3 CMR 18.00: Radiology
114.3 CMR 20.00: Clinical Laboratory Services

433.406: Individual Consideration

(A) A number of services are designated "I.C." (indicating individual consideration) in the service descriptions. This means that a fee could not be established for all cases. Appropriate payment for an individual consideration service will be determined by the Department's professional advisors from the physician's descriptive report of services furnished. If a report is not submitted, no payment will be made. (See Section 433.410 for report requirements.)

(B) Determination of the appropriate payment for an individual consideration service shall be in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the recipient's disease, disorder, or disability;
(4) the policies, procedures, and practices of other third-party insurers, both governmental and private; and
(5) any applicable relative-value studies.

433.407: Recommended Fees

For most individual consideration services, a recommended fee has been established; these services are designated "R.F." in the service descriptions. The recommended fees for such services are listed in Appendix D of the Physician Manual. For a service with a recommended fee, the physician may bill for the lower of either his usual fee or the recommended fee without attaching a report to the claim form. If the physician believes that the service merits a fee higher than that recommended, he must follow the instructions in Subchapter 5 of the Physician Manual for completing Block 21 of the claim form.

433.408: Prior Authorization

(A) Introduction.

(1) For all services not in the lists of service codes and descriptions and for those services that are designated

"P.A." in the service descriptions, the Department requires that the physician obtain prior authorization. No payment will be made for these services unless prior authorization has been obtained from the Department.

(2) A prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as recipient eligibility or resort to health insurance payment.

(B) Requesting Prior Authorization. All prior authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the Physician Manual.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

(1) certain surgery services;
(2) nonemergency services provided to a recipient by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border; and
(3) certain vision care services.

(D) Nonphysician Services Requiring Prior Authorization. Many nonphysician services require prior authorization, and must first be ordered, or have their need substantiated, by a physician before the Department grants such authorization. These services include, but are not limited to, the following:

(1) transportation;
(2) selected drugs;
(3) home health services;
(4) nursing home services;
(5) residential and day treatment programs;
(6) durable medical equipment; and
(7) therapy services.

433.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any service listed in this Chapter 433.000 is conditioned upon its full and complete documentation in the recipient's medical record. Payment for maintaining the recipient's medical record is included in the fee for the service.

(B) In order for a medical record to document completely a service or services to a recipient, that record must set forth the nature, extent, quality, and necessity of care furnished to the recipient. When the information contained in a

recipient's medical record is not sufficient to document the service for which payment is claimed by the provider, the Department will disallow payment for the claimed service.

(C) The Department may request, and the physician shall furnish, any and all medical records of recipients corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, s. 20, and 106 CMR 450.205. The Department shall produce, or at its option may require the physician to produce, photocopies of medical records in lieu of actual records when compliance with this section would otherwise result in removal of medical records from the physician's office or other place of practice.

(D) Medical records corresponding to office, home, nursing home, hospital outpatient department, and emergency room services provided to recipients must include the reason for the visit and the data upon which the diagnostic impression or statement of the recipient's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but shall not be limited to, the following:

(1) the recipient's name and date of birth;
(2) the date of each service;
(3) the name and title of the person performing the service, if the service is performed by someone other than the physician claiming payment for the service;
(4) the recipient's medical history;
(5) the diagnosis or chief complaint;
(6) clear indication of all findings, whether positive or negative, on examination;
(7) any medications administered or prescribed, including strength, dosage, and regimen;
(8) a description of any treatment given;
(9) recommendations for additional treatments or consultations, when applicable;
(10) any medical goods or supplies dispensed or prescribed; and
(11) any tests administered and their results.

When additional information is necessary to document the reason for the visit, the basis for diagnosis, or the justification for future diagnostic procedures, treatments, or recommendations for return visits or materials, such information must also be contained in the medical record. Basic data collected during previous visits (for example, identifying data, chief complaint, or history) need not be repeated in the recipient's medical record for subsequent visits. However, data that fully document the nature,

extent, quality, and necessity of care furnished to a recipient must be included for each date of service or service code claimed for payment, along with any data that update the recipient's medical course.

(E) For inpatient visit services provided in acute, chronic, or rehabilitation hospitals, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record shall be deemed to document services provided to recipients and billed to the Department if it conforms to and satisfies the medical records requirements set forth in the current Rules and Regulations for Hospitals in Massachusetts issued by the Massachusetts Department of Public Health. The physician claiming payment for any hospital inpatient visit service shall be responsible for the adequacy of the medical record documenting such service. The physician claiming payment for an initial hospital visit (Service Code 9071) must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(F) Additional medical records requirements for radiology, psychiatric, and other services can be found in the applicable sections of these regulations.

(G) Compliance with the medical records requirements set forth in, referred to in, or deemed applicable to these regulations shall be determined by a peer-review group designated by the Director of Medicaid as set forth in 106 CMR 450.206. The Department shall refuse to pay or, if payment has been made, shall consider such payment to be an overpayment as defined in 106 CMR 450.234 subject to recovery, for any claim that does not comply with the medical records requirements established or referred to in these regulations. Such medical records requirements shall constitute the standard against which the adequacy of records shall be measured for physician services, as set forth in 106 CMR 450.205(B).

433.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the physician's claim for payment when the service description stipulates "with report only", when the service is designated "I.C." in the service description, or when a service code for an unlisted procedure is used. This report must be sufficiently detailed to enable professional advisors to assess the extent and nature of the services.

(B) Operative Report. For surgery procedures designated "I.C." (individual consideration), operative notes must accompany the physician's claim. For surgery procedures designated "R.F.", operative notes must accompany the physician's claim, unless the recommended fee is claimed. An operative report must state the operation performed, the name of the recipient, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and his assistants, and the technical procedures performed.

433.411: Explanation of Abbreviations in Service Descriptions

The following abbreviations are used in the service descriptions.

(A) (P.A.) indicates that prior authorization is required (see Section 433.408).

(B) (I.C.) indicates that the claim will receive individual consideration to determine payment (see Section 433.406).

(C) (R.F.) indicates that a recommended fee has been established (see Section 433.407).

(D) (I.P.) indicates that the service is an independent procedure (see Subsection 433.401(P); for surgery procedures, see also Subsection 433.452(F)).

(E) (S.O.) indicates that a second opinion is required in most cases (see Section 433.453).

PART 2. MEDICAL SERVICES

433.412: Office Visits: Introduction

The office visits listed in Section 433.414 are of three types: adult, pediatric, and family planning. The distinction is made for administrative purposes only; fees for all three types of visits are the same.

(A) Adult Office Visits. The office visit service codes and descriptions in Subsection 433.414(A) apply only when the physician provides services other than family planning to recipients 21 years of age or older.

(B) Pediatric Office Visits. The office visit service codes and descriptions in Subsection 433.414(B) apply only when the physician provides services other than family planning to

recipients under 21 years of age. (For information on other services for children, see Sections 433.484 through 433.495.)

(C) Family Planning Office Visits. Regardless of the recipient's age, the service codes in Subsection 433.414(C) must be used when the primary purpose of an office visit is family planning. (See Sections 433.455 through 433.458 for regulations concerning abortion and sterilization.) The Department will pay for only those family planning supplies and medications listed in Subsection 433.414(C), at the physician's acquisition cost.

433.413: Office Visits: Service Limitations

(A) Time Limit. Payment for office visits is limited to one visit per day per recipient per physician.

(B) Office Visit and Treatment/Procedure. The physician may bill for either an office visit or a treatment/procedure but may not bill for both an office visit and a treatment/procedure to one recipient on the same date when they are performed in the same location. This limitation does not apply to a treatment/procedure that is performed as a result of a Project Good Health health assessment (see Sections 433.485 through 433.495); in such a case, the physician may bill for both a health assessment and a treatment/procedure. Examples of treatment/procedures are suturing, suture removal, aspiration of a joint, and cast application or removal. Certain diagnostic tests may be billed for in addition to an office visit. X rays and laboratory tests may be billed with an office visit.

(C) Obstetric Care. There is no all-inclusive fee for obstetric care. Office visits for prenatal and postpartum care must be billed for using the applicable adult or pediatric office visit service code (9001 through 9006 or 9031 through 9036, depending on the age of the recipient).

(D) Immunization or Injection. If the primary purpose of an office visit is an immunization or injection, the visit must be billed for as a minimal service visit (Service Code 9001, 9011, or 9031). The cost of the injectable material is also reimbursable if it is not distributed free of charge by the Massachusetts Department of Public Health and if its cost to the physician is more than $1.00. (See Section 433.440 on drugs dispensed in a physician's office.) (For allergy serums, see Section 433.424.)

433.414: Office Visits: Service Codes and Descriptions

(A) Adult Office Visits.

Service Code	Service Description
9001	Minimal service visit: a short follow-up office visit for a minimal service (for example, injection, immunization, change of dressing, etc.) performed by a physician or under his personal supervision. Approximate time: 5 minutes
9003	Routine office visit: an office visit for an intermediate examination, evaluation, and/or treatment. Approximate time: 10 to 20 minutes
9005	Extended office visit: an office visit for a thorough examination, evaluation, and/or treatment focusing on one or more organ systems, or providing a complete evaluation of the recipient. Approximate time: 30 minutes
9006	Office visit: unusual circumstances. Approximate time: 60 minutes (with report only)

(B) Pediatric Office Visits.

Service Code	Service Description
9031	Pediatric minimal service visit: a short follow-up office visit for a minimal service (for example, injection, immunization, change of dressing, etc.), performed by a physician or under his personal supervision. Approximate time: 5 minutes
9033	Pediatric routine visit: an office visit for an intermediate examination, evaluation, and/or treatment. Approximate time: 10 to 20 minutes
9035	Pediatric extended office visit: an office visit for a thorough examination, evaluation, and/or treatment focusing on one or more organ systems, or providing a complete evaluation of the recipient. Approximate time: 30 minutes
9036	Pediatric office visit: unusual circumstances. Approximate time: 60 minutes (with report only)

(C) Family Planning Office Visits.

Service Code	Service Description
9011	Family planning minimal service visit: a short family planning office visit for an examination, evaluation, and/or service performed by a physician or under his personal supervision. Approximate time: 5 minutes
9013	Family planning routine visit: a family planning office visit for an intermediate examination, evaluation, and/or service. Approximate time: 10 to 20 minutes
9015	Family planning extended visit: a family planning office visit for a thorough examination, evaluation, and/or service. Approximate time: 30 minutes
9016	Family planning visit: unusual circumstances. Approximate time: 60 minutes (with report only)
4739	IUD insertion: this code must be used in place of one of the above office visit codes when the office visit is for an IUD insertion. The cost of the IUD may be billed at the physician's acquisition cost. Removal of the IUD must be billed as a family planning office visit.
160009	Medications and injections related to family planning services with exception of Rho (D) human immune globulin (I.C.)
160010	Rho (D) human immune globulin (I.C.)
160011	Family planning supplies: birth control pills, IUD (other than the Copper 7 and Progestasert), diaphragm, contraceptive jelly, condoms, contraceptive foam (I.C.)
160012	Copper 7 (Cu-7) IUD (I.C.)
160013	Progestasert IUD (I.C.)

433.415: Hospital Emergency Room, Outpatient Department, and Courtesy Room Visits

(A) Emergency Room Visits. The Department will pay a physician for medical care provided in a hospital emergency room only when the hospital's claim does not include a charge for the physician's services.

(B) Outpatient Department and Courtesy Room Visits. The Department will pay a physician for medical care provided in a

hospital outpatient department or courtesy room only when the hospital's claim does not include a charge for the physician's services. The Department will pay 50 percent of the maximum allowable fee for the service.

(C) Billing. The office visit service codes and descriptions in Section 433.414 apply to hospital emergency room, outpatient department, and courtesy room visits.

433.416: Hospital Inpatient Visits: Service Limitations

(A) Hospital inpatient visit fees apply to visits by physicians to recipients hospitalized in acute, chronic, or rehabilitation hospitals. Payment is limited to one visit per day per recipient for the length of the recipient's hospitalization.

(B) Visits to recipients who have undergone or who are expected to undergo surgery are not reimbursable, since the allowable surgical fees include payment for the provision of routine inpatient preoperative and postoperative care. In unusual circumstances, however, visits to such recipients are reimbursable (Service Code 9075).

(C) Payment will be made only to the attending physician, with the following exceptions.

(1) A consultation is reimbursable (see Section 433.430 for regulations concerning consultations).

(2) If it is necessary for a physician other than the attending physician to treat a hospitalized recipient, the other physician's services are reimbursable (Service Code 9082 or 9083, concomitant or concurrent care). An explanation of the necessity of such visits must be attached to the claim form. The Department's Medical Advisor will review the claim and determine appropriate payment to the other physician.

(3) Intensive care services (Service Code 9078) are reimbursable.

(4) An emergency admission (Service Code 9079) is reimbursable.

(D) The Department will not pay for visits or services performed on days that are not certified by a Professional Standards Review Organization (PSRO) as medically or administratively necessary.

433.417: Hospital Inpatient Visits: Service Codes and Descriptions

Service Code	Service Description
9071	Initial hospital visit: a comprehensive history and physical examination, including initiation of diagnostic and treatment program and preparation of hospital records
9074	Limited examination, evaluation, and treatment: subsequent or follow-up visit
9075	Hospital visit: unusual circumstances: a hospital visit necessary because of preoperative or postoperative complications or the need for extended care (I.C.)
9077	Prolonged detention, each quarter-hour or fraction thereof (2 hours maximum)
9078	Intensive care services, each quarter-hour (2 hours maximum)
9079	Emergency admission
9082	Concomitant medical care: medical services provided by a physician other than the attending physician, in conjunction with surgical or obstetric services provided by the attending physician, for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy, which ordinarily would not be treated by the attending physician alone (I.C.)
9083	Concurrent medical care: medical services provided by a physician other than the attending physician in conjunction with medical services (rather than surgical or obstetric services) provided by the attending physician (I.C.)
9084	High-risk newborn care (per day): this fee is payable for each day the newborn is receiving premature or intensive care services requiring a respirator, constant monitoring, or intravenous therapy
9085	Attendance at high-risk delivery: at request of obstetrician; in lieu of first-day hospital visit for routine newborn, and first-day per diem for high-risk newborn

433.418: Nursing Home Visits: Service Limitations; Service Codes and Descriptions

(A) Requirement for Approval of Admission. The Department seeks to ensure that a Medical Assistance recipient receives

skilled nursing facility (SNF) and intermediate care facility (ICF) services only when available alternatives (see Sections 433.476 through 433.483) do not meet the recipient's need, and that every recipient receiving SNF or ICF services is placed appropriately according to the Department's level-of-care criteria. (For information on the level-of-care criteria and procedures for approval of admission, contact the Medical Division's Institutional Long-Term Care Unit at the address and telephone number in Appendix A of the Physician Manual.)

(B) Service Limitations. Payment for a visit by a physician to recipients in nursing homes or rest homes is limited to one visit per recipient per month, except in an emergency.

(C) Service Codes and Descriptions.

Service Code	Service Description
9053	Nursing home visit: a regular nursing home visit for a brief, limited, or intermediate examination, evaluation, and/or treatment, same or new illness, first recipient seen in nursing home
9058	Each additional recipient seen during a nursing home or extended nursing home visit
9054	Extended nursing home visit: an extensive visit by a physician for a thorough examination, evaluation, and/or treatment, focusing on one or more organ systems or providing a complete evaluation of a recipient. Approximate time: 30 minutes
9056	Emergency visit (with report only) (I.C.)
9055	Pronouncement of death in a nursing home, including completion of death certificate

433.419: Home Visits: Service Limitations; Service Codes and Descriptions

(A) Service Limitations. Payment for a visit by a physician to a recipient's home is limited to one visit per recipient per day. (For information on additional home health services reimbursable under the Medical Assistance Program, see Section 433.478.)

(B) Service Codes and Descriptions.

Service Code	Service Description
9067	Home visit: a regular home visit for a brief, limited, or intermediate examination, evaluation, and/or treatment, same or new illness, first recipient seen in residence
9068	Each additional recipient seen during a home or extended home visit
9069	Extended home visit: an extensive visit by a physician for a thorough examination, evaluation, and/or treatment, focusing on one or more organ systems or providing a complete evaluation of a recipient. Approximate time: 30 minutes (with report only)

433.420: Ophthalmology Services: Service Limitations

The comprehensive and routine follow-up eye examinations in Section 433.421 are reimbursable, subject to the following limitations.

(A) Prior authorization from the Department is required for a comprehensive eye examination (Service Code 9300) if the service has been furnished:

(1) within the preceding 12 months, for a recipient under 21 years of age; or

(2) within the preceding 24 months, for a recipient 21 years of age or older.

(B) The services designated "I.P." in the ophthalmology service descriptions in Section 433.421 are reimbursable only if performed independently of a comprehensive eye examination (Service Code 9300).

(C) Visual training (Service Code 9312) is reimbursable only if prior authorization is obtained and if it is provided independently of visual fields (Service Code 9315) and gross external examination with cycloplegic or mydriatic (Service Code 9310).

(D) Titmus vision test (Service Code 9347) or a similar screening device is reimbursable only once per year per recipient.

(E) Eyeglasses and other ophthalmic materials, with the exception of over-the-counter items such as magnifiers, may be

dispensed only upon prescription, even if the prescriber dispensed the materials himself. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to fill the prescription. The prescriber must provide the recipient with a signed copy of the prescription without extra charge. The date or dates upon which the prescription is filled or refilled must be recorded on the recipient's copy of the prescription. (For further regulations concerning ophthalmic materials, see the Department's regulations governing vision care services.)

433.421: Ophthalmology Services: Service Codes and Descriptions

For an explanation of anesthesia units, see Section 433.454.

Service Code	Anes. Units	Service Description
9300	-	Comprehensive medical eye examination with diagnosis and treatment, including but not limited to visual acuity determination, ophthalmoscopy, tonometry, gross visual fields, muscle balance, slit lamp microscopy, and refraction (for routine follow-up eye examinations that are less comprehensive than Service Code 9300, the appropriate outpatient or office visit service codes should be used, unless the codes listed below apply)
9305	3	Gonioscopy: adult
9306	3	Gonioscopy: infant (includes 7 days' follow-up aftercare) (I.P.)
9308	-	Gross external medical examination with ophthalmoscopy and tonometry (I.P.)
9310	-	with cycloplegic or mydriatic, which includes postcycloplegic visit
9311	-	Orthoptic and/or pleoptic evaluation (I.P.)
9312	-	training, each 30 minutes (I.P.) (P.A.)
9315	-	Visual fields: plotting, central, and/or peripheral

9316	-	Tonometry, without refraction, one or multiple readings, same day (I.P.)
9318	-	Tonography (recording tonometer method or perilimbal suction device) (I.P.)
9320	-	Provocative test(s) for glaucoma, including water drinking, and/or mydriatic, and/or dark-room test (I.P.)
9325	-	Ophthalmoscopy (fundoscopy) with mydriasis, direct and/or indirect methods (I.P.)
9326	3	with general anesthesia (I.P.)
9327	-	with contact lens
9328	-	with intravenous fluorescein (I.P.)
9332	-	with ophthalmodynamonetry (I.P.)
9333	-	Low-vision evaluation: (initial examination), series of vision tests to measure the degree of low-vision and corrective lenses required (I.P.)
9334	-	Replacement of single contact lens, hard (P.A.)
9335	-	Replacement of single contact lens, soft (P.A.)
9336	-	Contact lenses, hard (including fitting and evaluation) (I.P.) (P.A.)
9337	-	Contact lenses, soft (including fitting and evaluation) (I.P.) (P.A.)
9338	-	Single contact lens, soft (including fitting and evaluation) (I.P.) (P.A.)
9339	-	Single contact lens, hard (including fitting and evaluation) (I.P.) (P.A.)
9340	-	Contact lens as bandage (I.P.) (P.A.)
9341	-	Fundus photographs, each eye (I.P.) (P.A.)
9342	-	Electronystagmogram (ENG), each eye (professional component only) (I.P.)
9343	-	Ultrasonography (B-mode scan), each eye (professional component only) (I.P.)

9345 - Electroretinography, visual evoked response, each eye (I.P.)

9346 - Comprehensive vitreoretinal study, each eye (I.P.)

9347 - Titmus vision test (I.P.)

9349 - Not otherwise classified (I.C.)

433.422: Audiology Services: Service Limitations; Service Codes and Descriptions

(A) Service Limitations.

(1) Audiology services are reimbursable only when provided by a physician or by an audiologist certified by the American Speech and Hearing Association and employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only (Service Code 9350).

(2) Only physicians who have been approved by and received written authorization from the Department to perform hearing aid evaluations (Service Code 9367) will be paid for such services.

(3) The Department will pay for hearing aids only when the hearing aid evaluation is performed by an approved provider and only if prior authorization has been obtained.

(B) Service Codes and Descriptions.

Service Code	Service Description
9360	Routine audiological evaluation: includes audiometric hearing tests (pure-tone, air and bone, with or without masking) and speech discrimination and SRT tests.
9366	Complete audiological evaluation for site of lesion: includes routine audiological evaluation (Service Code 9360) and other tests as indicated, including but not limited to Bekesy audiometry, tone-decay test, SISI test (two or more frequencies), equal loudness-balance tests (or alternate binaural-balance tests)
9365	Complete audiological evaluation for functional (nonorganic) hearing loss: includes routine audiological evaluation (Service Code 9360) and other tests as indicated, including but not limited to psychogalvanic skin reflex tests, Bekesy audiometry, Stenger test, Doerfler-Stewart test, Lombard test, and delayed feedback test

9350	Audiometric hearing test, pure-tone, air only
9352	air and bone, with or without masking
9353	speech discrimination and SRT
9351	ABLB
9358	SISI
9362	Tone decay
9363	Bekesy, one ear
9364	Bekesy, both ears
9368	Stenger, Lombard, Doerfler-Stewart
9369	Impedance testing, complete battery
9373	tympanograms and compliance
9377	acoustic reflexes
9378	eustachian tube function
9380	Auditory training or lip reading, per hour
9367	Hearing aid evaluation: includes assessment of recipient's performance by appropriate tests with hearing aid devices; a recheck of recipient and hearing aid after prescribed aid has been fitted and used for trial period; and counseling related to recipient's adjustment to use of hearing aid
9379	Infant testing (with report only)
9389	Not otherwise classified (I.C.)

433.423: Otolaryngology Services: Service Codes and Descriptions

The following otolaryngology services are reimbursable only when provided by a physician.

Service Code	Service Description
9355	Vestibular function test: Hallpike calorics
9356	Vestibular function test: Kobrach

9358	Vestibular function test: rotation
9357	Electronystagmography (ear): calorics
9359	Electronystagmography (ear): spontaneous and positional testing
9354	Electronystagmography (ear): OPK, pendulum
9361	Electronystagmography (ear): rotation (with report only)

433.424: Allergy Testing: Service Limitations; Service Codes and Descriptions

The service codes and descriptions in Subsection (B) below apply to allergy testing performed by a physician or under a physician's direct supervision. All fees include payment for physician observation and interpretation of the tests in relation to the recipient's history and physical examination. A physician may bill for an initial consultation (see Service Codes 9150 through 9153 in Section 433.430) in addition to allergy testing.

(A) Service Limitations.

(1) Blood tests and pulmonary function tests (such as spirometry and expirogram) used only for diagnosis and periodic evaluation may not be claimed more than three times annually per recipient.

(2) Immunotherapy and desensitization (extracts) are reimbursable up to $5.00 per month per recipient (see Service Code 140001 in Subsection 433.440(D)). The amount and anticipated duration of the supply must be listed on the claim form.

(3) Follow-up office visits for injections and re-evaluation are reimbursable as office visits (see Service Codes 9001 through 9005 and 9031 through 9036 in Section 433.414).

(4) All sensitivity tests listed in Subsection (B) below are for one recipient during one year regardless of the type of tests performed or the number of visits required.

(B) Service Codes and Descriptions.

Service Code	Service Description
9500	Ten tests or fewer annually
9501	More than ten tests annually

9513 Mucous membrane test (ophthalmic, sublingual, and/or nasal), one to two tests

9514 each additional test (indicate number of tests)

9515 Direct bronchial mucosa (insufflation) testing (with report only)

9516 Passive transfer tests, one to ten tests

9517 each additional test (indicate number of tests)

(For thermogram, see Service Code 9436.)

9529 Not otherwise classified (I.C.)

433.425: Psychiatry Services: Introduction

(A) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for the psychiatric services listed in Subsection (B) below. (For other mental health services reimbursable for Medical Assistance recipients, see Section 433.472.)
(2) For General Relief recipients (category of assistance 04), psychotherapy provided by a physician in his office is the only reimbursable mental health service.

(B) Reimbursable Services.
(1) The Department will pay for individual, couple, family, and group psychotherapy, for consultations, and for medication provided by a physician.
(2) The Department will pay for electroconvulsive therapy only when it is provided in a hospital setting by a physician and only when both the physician and the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(C) Nonreimbursable Services.
(1) The Department will not pay a physician for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician.
(2) The Department will not pay a physician for experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, any unusual combination of treatments, or any session conducted for research rather than for a recipient's clinical

need.

(3) The Department will not pay for psychological testing provided by a physician.

(D) Recordkeeping (Medical Records) Requirements. Psychiatric medical records must be in compliance with the Department's general recordkeeping requirements (see Section 433.409). In addition, the following specific information must be included in the medical record for each recipient receiving psychiatric services:

(1) the condition or reason for which psychiatric services are provided;
(2) the recipient's diagnosis;
(3) the recipient's medical history;
(4) the recipient's social and occupational history;
(5) the treatment plan;
(6) the physician's short- and long-range goals for the recipient;
(7) the recipient's response to treatment; and
(8) if applicable, a copy of the signed consent for electroconvulsive therapy.

433.426: Psychiatry Services: Service Limitations

(A) Individual Psychotherapy. The Department will pay a physician for individual psychotherapy (Service Codes 9170, 9171, and 9172 in Section 433.427) provided to a recipient only when the physician himself treats the recipient.

(B) Couple and Family Therapy. Payment is limited to one payment per family therapy visit, regardless of the number of family members present.

(C) Group Therapy. The Department will pay for group therapy only if the session lasts for at least 90 minutes with the physician. Payment will be made for a maximum of six recipients, even if the number of Medical Assistance recipients in the group is more than six.

(D) Medication Review. The Department will not pay separately for medication review if it is performed on the same day as another service. A visit that is solely for medication review is reimbursable only as a minimal service office visit (see Service Code 9001 or 9031 in Section 433.414).

(E) Consultation. If a physician provides consultation services (see Service Codes 9150, 9151, and 9153 in Section 433.430), the Department will not pay for additional services provided to the recipient by the same physician on the day of the consultation.

(F) Hospital Inpatient Visit. A visit to a hospitalized recipient is reimbursable only as a hospital visit (see Section 433.417) unless at least 15 minutes of psychotherapy is provided, in which case the service codes in Section 433.427 may be used. Payment will be made for only one visit per recipient per day.

(G) Frequency of Treatment.

(1) The Department will pay a physician for only one session of each type of service provided to a recipient in one week. However, in a crisis, the Department will pay a physician for extra sessions. In this case, the physician must document in the recipient's record the following:

(a) the recipient is in a state of marked life change or crisis;

(b) the recipient's ability to function is likely to deteriorate; and

(c) the plan of treatment is to resume or to initiate regular weekly sessions after the resolution of the crisis.

(2) The Department will pay a physician for more than one type of service provided to a recipient in one week only if the additional service or services are medically necessary. The recipient's record must document the circumstances necessitating the provision of more than one type of service. The record must make clear that the substitution of one type of service for another would not adequately benefit the recipient and that an additional type of service is necessary.

433.427: Psychiatry Services: Service Codes and Descriptions

For an explanation of anesthesia units, see Section 433.454.

Service Code	Anes. Units	Service Description
9170	-	Psychotherapy (individual), office, home, or hospital; verbal, drug augmented, or other methods, at least 50 minutes
9171	-	at least 25 minutes
9172	-	at least 15 minutes
9175	-	Group therapy: each recipient, per one-and-one-half-hour session

9176	-	Group therapy: other situations (I.C.)
9179	-	Family therapy: two or more members of recipient's family, per one-hour session
9180	3	Convulsive therapy: electroconvulsive or drug induced, inpatient or outpatient, with or without anesthesia by treating physician

433.428: Dialysis: Service Limitations; Service Codes and Descriptions

(A) Medicare Coverage. Effective July 1973, Medicare was expanded to become the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Recipients being treated for chronic renal disease must be referred to their Welfare Service Office or Social Security Administration office to determine Medicare eligibility.

(B) Service Limitations. Service Codes 9260, 9262, and 9264 apply only to hospitalized recipients who are:

(1) being dialyzed for acute renal failure;
(2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or
(3) receiving dialysis for complications of chronic maintenance dialysis.

(C) Service Codes and Descriptions.

Service Code	Service Description
9260	Hemodialysis with artificial kidney, initial, for a hospitalized recipient only, maximum payment per recipient (not intended for chronic maintenance)
9262	second and/or third
9264	fourth through sixth
9265	seventh and subsequent, chronic
9267	Peritoneal dialysis, initial
9268	subsequent, if reinsertion of cannula is necessary (maximum of four times)

433.429: Physical Medicine: Service Limitations; Service Codes and Descriptions

(A) Service Limitations.

(1) The services listed in this section are reimbursable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician.

(2) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are reimbursable under the Medical Assistance Program upon referral by a physician (see Section 433.471).

(B) Service Codes and Descriptions.

Service Code	Service Description
9600	Office visit: for all physical medicine procedures, brief (up to 15 minutes)
9601	routine (in excess of scope of brief visit, up to 60 minutes)

433.430: Consultations: Service Limitations; Service Codes and Descriptions

Only one consultation per recipient per case episode is reimbursable. If the consultant assumes the continuing care of the recipient, services are reimbursable only under the applicable service codes.

Service Code	Service Description
9150	Limited consultation: requiring limited or more extensive examination and/or evaluation but not requiring a comprehensive history and examination; office, home, or hospital
9151	Extended consultation: requiring comprehensive history and examination and/or evaluation; office, home, or hospital
9153	Consultation of unusual complexity: in excess of scope of services identified by Service Code 9151; necessitating

history and examination, extensive review of prior medical records as indicated, compilation and assessment of data, and the preparation of a special report; office, home, or hospital (with report only)

433.431: Other Medical Procedures: Service Codes and Descriptions

(A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed for in addition to an office visit.

Service Code	Service Description
	Cardiovascular
9370	Electrocardiogram, with interpretation and report
9371	Taking ECG only
9372	ECG interpretation and report only
9374	ECG, with exercise test
9383	Phonocardiogram, with interpretation and report
9384	with indirect carotid artery tracing or similar study
9385	Vectorcardiogram (VCG), with or without ECG, interpretation and report
9387	Cardiac pacemaker analysis (includes ECG and electronic analysis of pacemaker in office or by telephone)
9376	Cardiovascular stress testing (with report only) (R.F.)
9430	Peripheral vascular disease studies (with report only) (I.C.)
9432	Plethysmography, total body (with report only) (R.F)
9433	regional (with report only) (R.F.)
9399	Not otherwise classified (I.C.)

Other Vascular Studies

9435 Temperature gradient studies (with report only)

9436 Thermogram (with report only)

9449 Not otherwise classified (I.C.)

(B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure. (For consultation services, see Service Codes 9150 through 9153 in Section 433.430.)

Service Code	Service Description
9410	Independent evaluation of cardiac catheterization data and report
9415	Dye dilution studies, indicator dye curves, including arterial cannulization (I.P.)
9416	with cardiac output measurement, initial (I.P.)
9417	subsequent, same study period, each

(C) Pulmonary Procedures. Fees for the procedures listed below include payment for laboratory procedures, interpretations, and physician's services. These services may be billed for in addition to an office visit.

Service Code	Service Description
9450	Spirometry, complete, including graphic record, total and timed vital capacity, and maximal breathing capacity (with report only)
9453	Bronchospirometry: measurement of differential ventilation and oxygen consumption (I.P.) (see also Service Code 2201)
	(For insertion of tube, see the section on Trachea and Bronchi in the Surgery Service Codes and Descriptions.)
9454	Bronchospasm evaluation: spirometry as in Service Code 9450 before and after bronchodilator (aerosol or parenteral)

9455	Vital capacity, total
9456	Vital capacity, total and timed (forced expiratory volumes)
9460	Maximal breathing capacity (maximum voluntary ventilation)
9461	Maximal expiratory flow rate measurement or equivalent (I.P.)
9463	Residual air (helium method), including equilibration time
9465	Residual air (open circuit method), including alveolar nitrogen
9467	Nitrogen washout curve (continuous) (with report only)
	(For plethysmography, see the section on Cardiovascular.)
9474	Arterial blood gas study (including cannulization of artery, measurement of arterial oxygen saturation, PO_2, PCO_2, CO_2 content, and pH), rest only
9476	rest and exercise
9477	including comprehensive medical evaluation, arterial blood gases, and three or more pulmonary function studies
9480	Carbon monoxide diffusing capacity (with report only)
9483	Pulmonary compliance (with report only)
9485	Carbon dioxide expired gas determination by infrared analyzer (with report only)
9499	Not otherwise classified (I.C.)

(D) Dermatological Special Procedures. These services may be billed for in addition to an office visit.

Service Code	Service Description
9519	Actinotherapy (ultraviolet light), local
9520	Actinotherapy (ultraviolet light), general

(E) Miscellaneous Procedures.

Service Code	Service Description
9258	Application of scalp electrode and placement of intrauterine catheter for total monitoring during labor (I.C.)
9530	Exclusion tests for pheochromocytoma (e.g., regitine, benzodioxane, histamine, etc.)
9531	Fetal stress testing
9532	Fetal nonstress testing
9533	Electroencephalogram (EEG), awake, asleep (natural or induced), and activation
9534	interpretation and report only
9535	Muscle testing, manual, per extremity or trunk (with report only)
9536	total evaluation of body
9540	Range of motion measurements and report, each extremity (I.P.)
9542	Electromyography, one extremity and related paraspinal area
9543	two extremites and related paraspinal areas
9544	four extremities and related paraspinal areas
9545	Nerve conduction velocity study, motor or sensory, each nerve
9546	contralateral nerve
9547	Motor and sensory, each nerve
9548	contralateral nerve
9550	Additional ipsolateral or contralateral nerve, each
9552	Achilles reflex response, electrical recording (ART)
9559	Not otherwise classified (I.C.)
9560	Cardiopulmonary resuscitation (e.g., cardiac arrest) (with report only) (R.F.)
9563	Electrical conversion of arrhythmia, external (I.P.)

9567 Perfusion for malignancy through laparotomy

9569 Infusion through neck arteries percutaneously or by cutdown for malignancy, unilateral

9570 bilateral

9571 Perfusion for malignancy with pump oxygenator, unilateral

9572 bilateral

9573 Desensitization (e.g., horse serum) (with report only) (R.F.)

9574 Gastric lavage treatment (e.g., ingested poisons) (with report only)

9575 Hyperbaric oxygen pressurization, initial (with report only)

9576 subsequent (with report only)

9580 Hypothermia, regional (with report only) (R.F.)

9581 total body (with report only) (R.F.)

9585 Phlebotomy, therapeutic (I.P.)

9599 Not otherwise classified (I.C.)

(F) Unlisted Procedures. Service Code 9299 should be used only if there is no "Not otherwise classified" code in the appropriate section.

Service Code	Service Description
9299	Unlisted procedure (with report only) (I.C.)

(106 CMR 433.432 through 433.435 Reserved)

433.436: Radiology Services: Introduction

The Department will pay for the radiology services in Section 433.602 only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Eligible Recipients.

(1) For Medical Assistance recipients (categories of

assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for the radiology services in Section 433.602.

(2) For General Relief recipients (category of assistance 04), the Department pays only for radiology services provided in a physician's office; the Department will not pay for any portion of a radiology service provided to a General Relief recipient by or in a hospital.

(B) Provider Eligibility. A provider of portable X-ray services is eligible to participate in the Medical Assistance Program only if the provider is certified by Medicare.

(C) Request for Portable X-Ray Services. Portable X-ray services may be provided only to a recipient at home or in a long-term care facility and only at the written request of a licensed physician. This written request must specify the reason the X ray is required, the area of the body to be exposed, the number of radiographs to be obtained, the views needed, and a statement of the recipient's condition that necessitates portable X-ray services. If the recipient resides in a long-term care facility, a copy of this written request must be kept in the recipient's medical record in the facility as well as in the recipient's record maintained by the physician.

(D) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see Section 433.409), the physician must keep suitable records of radiology services performed. All X rays must be labeled adequately with the following:

(1) the recipient's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

(A) Private Office. The Department will pay a physician 100 percent of the maximum allowable fee for performing a radiology service in his private office when the physician owns the equipment and is his own technician or employs a technician.

(B) Portable X-Ray Services. When a physician provides portable X-ray services to a recipient at home or in a long-term care facility, the Department will pay for the X rays according to the appropriate radiology service codes and

descriptions in Section 433.602. Regardless of the number of recipients receiving portable X-ray services in that home or facility, the Department will pay only once for Service Code 7577 for the visit to that home or facility.

(C) Computerized Axial Tomography (CT Scans). CT scan services (head and body scans) are reimbursable by the Department only when performed in a facility having a Determination of Need for a CT scanner by the Massachusetts Department of Public Health. The Department will pay a physician directly only for the professional component (interpretation) of a CT scan. All CT scan services must meet current Medicare standards.

(D) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the Department will pay the physician 40 percent of the maximum allowable fee. The Department will not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the Department will pay a physician for interpreting an X ray that was previously read and taken in a different hospital, according to the appropriate service description in Section 433.602.

(E) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the Department will pay the physician 50 percent of the maximum allowable fee.

(F) Surgical Introductions and Interpretations. The Department will pay a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

(1) Only one surgical introduction per operative session is reimbursable at 100 percent of the maximum allowable fee.

(2) In a single operative session:

(a) no more than three additional surgical introductions using the same puncture site are reimbursable, each at 50 percent of the maximum allowable fee; and

(b) no more than three additional selective vascular studies (Service Codes 2576, 2577, 2578, and 2579) using the same puncture site are reimbursable, each at the maximum allowable fee.

(3) Interpretations are reimbursable at 40 percent of each maximum allowable fee, up to a maximum of three.

(G) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a recipient by one or more physicians are reimbursable only if sufficient documentation for each is shown in the recipient's medical record.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a recipient are reimbursable under the Medical Assistance Program.

(A) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for the clinical laboratory services in Section 433.601.
(2) For General Relief recipients (category of assistance 04), the Department pays only for clinical laboratory services provided in a physician's office; the Department will not pay for clinical laboratory services provided to a General Relief recipient by or in a hospital.

(B) Provider Eligibility. The laboratory service codes and descriptions in Section 433.601 apply only to tests performed on a recipient by a physician or by an independent laboratory certified by Medicare.

(C) Payment. The Department will pay a physician only for laboratory tests performed in his office. If a physician uses the services of an independent laboratory, the Department will pay only the laboratory for services provided for a recipient.

(D) Information with Specimen. A physician who sends a specimen to an independent laboratory participating in the Medical Assistance Program must also send the following:
(1) a signed request for the laboratory services to be performed;
(2) the recipient's 9- or 10-digit card holder number and 2-digit suffix number, both of which appear on the recipient's Eligibility Card; and
(3) the physician's 7-digit provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The Department will not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example,

venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the Department will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per recipient specimen, regardless of the number of tests to be performed on that specimen (Service Code 108817).

(B) Professional Component of Laboratory Services. The Department will not pay a physician for the professional component of a clinical laboratory service. The Department will pay a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The Department will not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. The fees for laboratory services include payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests. In no event shall a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

433.440: Drugs: Dispensing

(A) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for drugs, except as outlined in Subsection (B) below.

(2) For General Relief recipients (category of assistance 04), as required by the General Laws of Massachusetts, only life-sustaining drugs are reimbursable. The Department pays for life-sustaining drugs in the following therapeutic classes for General Relief recipients:

CA--Antineoplastic Agents
OP--Ophthalmic Preparations
04--Antispasmo Anticholinerg
07--Major Tranquilizers
08--Oral Muscle Relaxants
11--Psychostimulants
15--Bronchial Dilators
21--Broad Spectrum Antibiotics
22--Penicillin
24--Sulfonamides
25--Antibiotics Sulfa
27--Other Nonsystemic Antibiotics
28--Urinary Antibacterial Analgesics
31--Amebicides Trichomonas
32--Antimalarials
33--Anthelmintics
34--TB Preparations
39--Antialcoholic
48--Anticonvulsant (including Phenobarbital, Luminal, and Mebaral)
51--Corticoids, Plain and Injectable
55--Thyroid Preparations
56--Antithyroid Preparations
58--Diabetic Therapy
70--Rauwolfias
71--Other Hypotensives
72--Vasodilators Coronary
74--Digitalis Preparations
75--Xanthine Derivatives
76--Other Cardiovascular Preparations
77--Anticoagulants
78--Hemostatics
79--Diuretics
87--Electrolytes and Miscellaneous Nutriments

(B) Service Limitations. The Department will pay for legend drugs except as outlined below. The Department will pay for the nonlegend drugs listed in the Drug and Medical Supply List; this list is sent to pharmacies by the Department.

(1) Methyl Phenidate (Ritalin) and Amphetamines. The Department does not pay for methyl phenidate (Ritalin), amphetamines (including amphetamines in combination), or any other drugs when they are used for control of the appetite. When prescribed for the treatment of hyperkinesis, however, such drugs are reimbursable without prior authorization if the recipient is under 17 years of age.

(2) Vitamin B_{12}. Vitamin B_{12} is reimbursable only for a recipient having a diagnosis of pernicious anemia. The medical record must document the recipient's medical history as well as the physical and laboratory findings that support such a diagnosis. An office, home, or hospital outpatient visit for the sole purpose of administering vitamin B_{12} is reimbursable only if the B_{12} therapy is reimbursable.

(3) Vitamins. The Department pays for vitamins included on the Drug and Medical Supply List only when they are dispensed to infants or children through the age of 36 months or to pregnant women. Plain fluorides are reimbursable when they are dispensed to recipients up to the age of 12 years. General multiple viamins NF (National Formulary)

in a unit of 100 are reimbursable without age restriction.
(4) Iron. The Department pays for only those iron preparations included in the Drug and Medical Supply List.
(5) Immunizing Biologicals and Tubercular Drugs.
(a) Immunizing biologicals and tubercular (TB) drugs available free of charge through local boards of public health or through the Massachusetts Department of Public Health are not reimbursable. If the recipient cannot attend one of the Department of Public Health clinics, however, the Department will pay for the following drugs: Isoniazid, Myambutal, and P.A.S.
(b) Subsection (5)(a) above notwithstanding, the Department does pay for pneumococcal vaccine.
(6) Allergy Serums. For regulations concerning payment for allergy serums, see Section 433.424.
(7) Antacids. The Department pays for antacids only when dispensed to a noninstitutionalized recipient and only if the recipient has gastritis, hiatus hernia, or ulcers.
(8) Laxatives and Stool Softeners. The Department does not pay for laxatives or stool softeners.
(9) Cough and Cold Preparations. The Department does not pay for legend or nonlegend preparations that contain a decongestant, antitussive, or expectorant as a major ingredient when dispensed to a noninstitutionalized recipient.
(10) Propoxyphene. The Department does not pay for any drug product that contains propoxyphene, with the following two exceptions:
(a) propoxyphene hydrochloride 32 mg.; and
(b) propoxyphene hydrochloride 65 mg.
(11) Hexachlorophene Preparations. The Department does not pay for preparations containing hexachlorophene, U.S.P. as the major active ingredient.
(12) Less-Than-Effective Drugs. The Department does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a notice of opportunity for hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications. (Examples of drug products affected by this regulation are listed in Appendix H of the Physician Manual.)

(C) Payment. Drugs dispensed in the office are reimbursable only when the cost to the physician is more than $1.00. Drugs are reimbursable at the actual acquisition cost not to exceed the average wholesale price listed in the current edition of or supplements to the Drug Topics Red Book. Claims for dispensing drugs must include the following information: the name of the drug or biological; the strength; and the dosage. Claims without this information will be denied. Payment for drugs may be claimed in addition to an office visit (see Subsection (D) below).

(D) Service Code and Description.

Service Code	Service Description
140001	Medical supplies, medications, and injectables not related to family planning (I.C.)

433.441: Medical Supplies: Dispensing

(A) Payment. Medical supplies dispensed in the office are reimbursable at the physician's acquisition cost if this cost is more than $1.00. Claims for dispensing medical supplies must include the following information: a complete description of the item; the acquisition cost (supplier's invoice amount); the quantity dispensed; and whether the item is standard or custom-made. Payment for medical supplies may be claimed in addition to an office visit (see Subsection (B) below).

(B) Service Code and Description.

Service Code	Service Description
140001	Medical supplies, medications, and injectables not related to family planning (I.C.)

(106 CMR 433.442 through 433.450 Reserved)

PART 3. SURGERY SERVICES

433.451: Surgery Services: Introduction

(A) Provider Eligibility. A physician will be paid for surgery only if he is scrubbed and present in the operating room during the major portion of the operation.

(B) Reimbursable Services. All services listed in Section 433.603 are reimbursable subject to Department regulations and the following limitations.

(1) Cosmetic surgery is not reimbursable except when medically necessary.

(2) Experimental or unproven procedures are not reimbursable.

(3) Some surgery procedures require a second opinion

before they are reimbursable (see Section 433.453).
(4) Abortion and sterilization procedures are reimbursable subject to specific Department regulations (see Sections 433.455 through 433.458).
(5) Hysterectomies are reimbursable subject to specific Department regulations (see Section 433.459), and only if a second opinion is obtained (see Section 433.453).

433.452: Surgery Services: Payment

The maximum allowable fees for the surgery services listed in Section 433.603 apply to surgery procedures performed in any setting. The Department will pay a physician for either a visit or a treatment/procedure, whichever commands a higher fee; the Department will not pay for both a visit and a treatment/procedure provided to a recipient on the same day when they are performed in the same location. All maximum allowable fees for surgery procedures include payment for the initial application of casts, traction devices, or similar appliances.

(A) Obstetrics.
(1) Obstetric fees include payment for procedures performed and care given to a recipient in a hospital or at home. However, the Department will give individual consideration to a claim for extended obstetric preoperative or postoperative care due to unusual circumstances, if the physician requests it and attaches adequate medical documentation to the claim form.
(2) There is no all-inclusive fee for obstetric care. Office visits for prenatal and postpartum care are reimbursable at the applicable office visit fee. Claims for these visits must be received by the Department within 90 days after the date of service.

(B) Inpatient Services.
(1) For surgery procedures performed on an inpatient in a licensed hospital, the fees include payment for preoperative diagnosis and postoperative care during the period of hospitalization.
(2) The Department will give individual consideration to a claim for extended preoperative or postoperative care due to unusual circumstances (Service Code 9075), if the physician requests it and attaches adequate medical documentation to the claim form.
(3) A physician who performs an inpatient surgery procedure but does not provide the postoperative care will be paid 85 percent of the maximum allowable fee. The physician providing the postoperative care will be paid

according to the applicable office, hospital, or home visit fee.

(C) Surgical Assistants. No payment will be made to a surgical assistant for a procedure with an allowable fee of less than $63.75. For other procedures, a surgical assistant will be paid 15 percent of the maximum allowable fee, with a minimum payment of $20.00.

(D) "Team" Surgery. When two or more physicians participate in an operative procedure, and when each physician contributes an expertise because of specialty training and performs a discrete portion of the operative procedure, the physician who is the consulting surgeon will be paid on an individual consideration basis. To claim payment, each consulting surgeon must use Service Code 9299 on the claim form he submits and must attach to it a complete operative report, including a description of each consulting surgeon's role. The physician who is the primary surgeon (surgeon of record) should bill in the usual manner.

(E) Multiple Procedures. In most circumstances, the Department will pay for only one operative procedure in a single operative session. For example, it is inappropriate to request payment for both an exploratory laparotomy and an appendectomy, or for both an arthrotomy and a meniscectomy. When two definitive procedures are performed during the same operative session, and neither procedure is designated "I.P." (for independent procedure) (see Subsection (F) below), the full maximum allowable fee will be paid for one procedure, and 50 percent of the maximum allowable fee will be paid for each additional procedure.

(F) Independent Procedures. A number of surgery procedures are designated "I.P." in the service descriptions in Section 433.603. I.P. is an abbreviation for independent procedure. An independent procedure is reimbursable only when no other procedure is performed during the same operative session, unless one of the exceptions in Subsections (1) through (3) below applies.

(1) When during the same operative session an additional surgery procedure performed by the same physician is designated "I.P." and requires an unrelated operative incision, the full maximum allowable fee will be paid for the procedure with the largest fee, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein. In the event that two or more procedures are scheduled at the largest amount, the full maximum allowable fee will be paid for only one of

the procedures, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein.

(2) When during the same operative session one or more of the surgery procedures performed by the same physician is designated "I.P." and does not require an unrelated operative incision, the maximum allowable fee will be paid for the procedure commanding the largest fee, and no payment will be made for any other procedure.

(3) When during the same operative session all of the surgery procedures performed by the same physician are designated "I.P." and one or more requires an unrelated operative incision, payment shall be determined on the basis of individual consideration.

433.453: Surgery Services: Consultation Program for Elective Surgery (Second Opinion Program)

(A) Introduction. In order to implement the Legislature's mandate for a Second Surgical Opinion Program, the Department has established the Consultation Program for Elective Surgery (Program). The Program is designed to obtain independent judgments from qualified specialists prior to the performance of certain elective procedures for Medical Assistance recipients. Any recipient who does not have private health insurance or Medicare coverage and for whom any of the surgery procedures listed in Subsection (B) below has been recommended must complete the Program's review process. Medical Assistance recipients who have private health insurance or Medicare coverage need not participate in the Program.

(B) Elective Surgery Procedures. The following are the elective surgery procedures for which the Program's review process is required:

(1) tonsillectomy and/or adenoidectomy;
(2) hysterectomy;
(3) hemorrhoidectomy;
(4) meniscectomy;
(5) submucous resection/rhinoplasty, repair of nasal septum;
(6) excision of varicose veins; and
(7) disc surgery/spinal fusion.

These procedures are designated "S.O." in the surgery service descriptions in Section 433.603.

(C) Review Process. The physician proposing to perform the surgery, whether on an inpatient or outpatient basis, must initiate the review process by contacting the Department-designated referral center assigned to the hospital where the

proposed surgery is to take place. There are five referral centers in Massachusetts (see Appendix E of the Physician Manual for a list of referral centers). Each referral center covers an area that corresponds to one of the five Professional Standards Review Organization (PSRO) regions. The Program uses two different review processes: criteria review and consultation. The nature of the proposed surgery determines which process is applicable. The referral center should be contacted for this information.

(1) Criteria are used to screen recipients for whom certain designated procedures have been proposed. If the recipient's medical condition meets the established criteria, the review process is complete, and the surgery and associated medical care are reimbursable. If the recipient's medical condition does not meet the established criteria, the referral center will notify the proposing physician and the recipient that the recipient must fulfill the consultation requirement specified in Subsection (2) below.

(2) If a consultation is required, the referral center will schedule an appointment for the recipient with a qualified consultant as defined in each referral center contract with the Department. If the consultant confirms the need for surgery, the review process is complete, and the surgery and associated medical care are reimbursable. If the consultant does not confirm the need for surgery, the referral center will notify the proposing physician and the recipient of the consultant's decision and of any recommendations. The referral center will then schedule a second consultation at the request of the recipient. The Department will not pay for the surgery and associated medical care unless the recipient requests and receives a second consultation. After the second consultation, the review process is complete, and the surgery and associated medical care are reimbursable regardless of whether or not the second consultant confirms the need for surgery.

(D) Waiver of the Consultation Requirement. A recipient will be exempt from the Program's consultation requirement if the referral center issues either of the waivers listed below.

(1) Travel Waiver. The referral center will issue a travel waiver if there is no qualified consultant in the appropriate field within a 10- to 15-mile radius of the recipient's residence. However, if the recipient is willing to travel more than the 10 to 15 miles, reimbursement for travel expenses can be arranged by the recipient's social worker.

(2) Special-Consideration Waiver. The referral center will issue a special-consideration waiver if it determines

that there are unusual medical circumstances in which requiring a consultation would result in undue hardship to the recipient. If the referral center issues a special-consideration waiver, the proposing physician will be responsible for supplying the referral center with post-operative medical documentation for purposes of retrospective review.

(E) Notification. The referral center will inform the proposing physician and the recipient of the outcome of each consultation. Upon the completion of the review process or the issuance of a waiver, the referral center will send written notification to the proposing physician, the recipient, and the hospital that the surgery and associated medical care are reimbursable.

(F) Billing. In order to receive payment for any of the elective procedures in Subsection (B) above, the physician must use the appropriate prefix with the service code on the claim form (see the instructions in Subchapter 5 of the Physician Manual for completing Block 18 of the claim form). The physician must also attach a copy of the approval letter to the claim form.

(G) Proposing Physician's Responsibility in the Program. It is the responsibility of the proposing physician to inform the recipient of the Program's review requirements and to initiate the review process by contacting the appropriate referral center (see Appendix E of the Physician Manual for a list of referral centers). The proposing physician must not arrange a consultation independently of the referral center, and he must provide the referral center with the recipient's medical history and any pertinent test results. Prior to the recipient's admission to the hospital or the performance of the surgery procedure, the physician must have received notification from the referral center that the recipient has fulfilled the Program's requirements.

(H) Consultant's Responsibility in the Program. The consultant must provide the referral center with the required consultation forms indicating his recommendations within five working days after the consultation. The consultant must bill the referral center, not the Department or the recipient, for the consultation. Consultants and their associates must not perform the recommended surgery procedure or provide any other related medical treatment for recipients for whom they have provided a first or second consultation.

(I) Hospital's Responsibility in the Program. When the primary purpose of a recipient's admission to the hospital is the

performance of any of the elective procedures in Subsection (B) above, the hospital must have received written notification of the completion of the Program's requirements prior to the recipient's admission to the hospital.

(J) Program Restrictions.

(1) No physician will be paid for furnishing any medical or surgery service related to the performance of a designated elective procedure unless the recipient has completed the Program's requirements.

(2) If a physician suspects that a diagnostic procedure (for example, dilation and curettage or arthroscopy) will reveal that a surgery procedure requiring a second opinion should be performed during the same operative session, he must contact the referral center to arrange a consultation before proceeding with the examination.

(3) If a recipient requires a second consultation, he must request the consultation within six months after the date of the first consultation, or he will be required to re-enter the Program.

(4) Surgery must be performed within six months after the completion of the Program's requirements, or the recipient will be required to re-enter the Program.

433.454: Anesthesia Services

(A) Payment.

(1) Payment for anesthesia services is determined by a system of base anesthesia units and time units. The surgery and medical service codes and descriptions list the number of base anesthesia units for each service. To this number, the Department adds one additional unit for each quarter hour or fraction thereof, provided such fraction equals or exceeds five minutes, according to the time-unit information entered on the claim form. If no base anesthesia units are listed for a service, payment is determined by time units alone. The time-unit period begins at the moment of the actual administration of the anesthetic agent and ends when the anesthetic procedure terminates. (See the instructions in Subchapter 5 of the Physician Manual for completing Block 19 of the claim form.)

(2) The base anesthesia units listed with the service codes and descriptions are the maximum number of base units used to determine the fee. The number of base units is the same, regardless of the type of anesthesia administered, including acupuncture (see Subsection (C) below).

(3) When anesthesia is administered for multiple surgery procedures, only the base anesthesia units for that procedure with the largest number of units will be applied in computing the maximum allowable fee.

(B) Services Provided by a Nurse-Anesthetist. Anesthesia services provided by a nurse-anesthetist are reimbursable only if the nurse-anesthetist meets the following conditions:

(1) is authorized by law to perform the services for which payment is sought;

(2) is a full-time employee of the physician and is not a salaried employee of the hospital; and

(3) performs the services under the direct and continuous supervision of the physician.

The physician must be in the operating suite and responsible for no more than two operating rooms. Availability of the physician by telephone does not constitute direct and continuous supervision.

(C) Acupuncture as an Anesthetic. Evidence indicates that acupuncture may be safely and effectively used in lieu of a general anesthetic. The Department will pay for acupuncture only as a substitute for conventional surgical anesthesia.

433.455: Abortion Services

(A) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for abortion services.

(2) For General Relief recipients (category of assistance 04), the Department does not pay for abortion services.

(B) Reimbursable Services.

(1) The Department will pay for an abortion service if both of the following conditions are met:

(a) the abortion is a medically necessary abortion, or the abortion is performed upon a victim of rape or incest when such rape or incest has been reported to a law enforcement agency or public health service within 60 days of the incident; and

(b) the abortion is performed in accordance with M.G.L. c. 112, s. 12K through 12U.

(2) For the purposes of this section, a medically necessary abortion is one that, according to the medical judgment of a licensed physician, is necessary in light of all factors affecting the woman's health.

(3) Unless otherwise indicated, all abortions referred to in this section are payable abortions as defined in Subsections (1) and (2) above.

(C) Assurance of Recipient Rights. No provider shall use any form of coercion in the provision of abortion services. Neither the Department nor any provider, nor any agent or

employee of a provider, shall mislead any recipient into believing that a decision to have or not to have an abortion will adversely affect the recipient's entitlement to benefits or services for which the recipient would otherwise be eligible. The Department has strict requirements for confidentiality of recipient records for abortion services as well as for all other medical services reimbursable under the Medical Assistance Program.

(D) Locations in Which Abortions May Be Performed. In accordance with M.G.L. c. 112, s. 12I through 12N, inserted by Chapter 706 of the Acts of 1974, and with license rules and regulations of the Massachusetts Department of Public Health, abortions must be performed in compliance with the following.

(1) First-Trimester Abortion. A first-trimester abortion must be performed by a licensed and qualified physician in a clinic licensed by the Department of Public Health to perform abortions, or in a hospital licensed by the Department of Public Health to perform abortions.

(2) Second-Trimester Abortion. A second-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform abortions and to provide facilities for general surgery.

(3) Third-Trimester Abortion. A third-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform abortions and to provide facilities for obstetric services.

(E) Certification for Payable Abortion Form. All physicians must attach a completed Certification for Payable Abortion (CPA-2) form to each claim form submitted to the Department for a payable abortion. (Instructions for obtaining the Certification for Payable Abortion form are in Subchapter 5 of the Physician Manual.) To identify those abortions that meet federal reimbursement standards, specified in 42 CFR 449.100 through 449.109, the Department must secure on the CPA-2 form the certifications described in Subsections (1), (2), and (3) below, when applicable. For all medically necessary abortions not included in (1), (2), or (3), the certification described in Subsection (4) below is required on the CPA-2 form. The physician must indicate on the CPA-2 form which of the following circumstances is applicable, and must complete that portion of the form with the appropriate signatures.

(1) Life of the Mother Would Be Endangered. The attending physician must certify that, in his professional judgment, the life of the mother would be endangered if the pregnancy were carried to term.

(2) Severe and Long-Lasting Damage to Mother's Physical Health. The attending physician and another physician must each certify that, in his professional judgment, severe and long-lasting damage to the mother's physical health would result if the pregnancy were carried to term. At least one of the physicians must also certify that he is not an "interested physician", defined herein as one whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest. The physician is responsible for submitting with the claim form signed documentation from a law enforcement agency or public health service certifying that the person upon whom the procedure was performed was a victim of rape or incest that was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services, or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from the victim), and a statement that the report included the signature of the person who made the report.

(4) Other Medically Necessary Abortions. The attending physician must certify that, in his medical judgment, for reasons other than those described in Subsections (1), (2), and (3) above, the abortion performed was necessary in light of all factors affecting the mother's health.

433.456: Sterilization Services: Introduction

(A) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for sterilization services.

(2) For General Relief recipients (category of assistance 04), the Department pays only for sterilization services performed in a physician's office.

(B) Reimbursable Services. The Department will pay for sterilization services provided to a recipient only if all of the following conditions are met:

(1) the recipient has voluntarily given informed consent for the sterilization procedure in the manner and at the

time described in Section 433.457, and such consent is documented in the manner described in Section 433.458;
(2) the recipient is at least 18 years old at the time consent is obtained; and
(3) the recipient is not mentally incompetent or institutionalized.

(C) Locations in Which Sterilizations May Be Performed.
(1) Male sterilization by vasectomy must be performed by a licensed physician in a physician's office, hospital, or ambulatory sterilization clinic.
(2) Female sterilization by laparoscopy must be performed by a licensed physician either in a hospital or ambulatory sterilization clinic. All other types of female sterilization must be performed by a licensed physician in a hospital.

(D) Assurance of Recipient Rights. No provider shall use any form of coercion in the provision of sterilization services. Neither the Department nor any provider, nor any agent or employee of a provider, shall mislead any recipient into believing that a decision to have or not to have a sterilization will adversely affect the recipient's entitlement to benefits or services for which the recipient would otherwise be eligible. The Department has strict requirements for confidentiality of recipient records for sterilization services as well as for all other medical services reimbursable under the Medical Assistance Program.

433.457: Sterilization Services: Informed Consent Requirements

(A) When Informed Consent Must Be Obtained.
(1) Informed consent for sterilization must be given by the recipient at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A recipient may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the recipient gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
(2) Informed consent for sterilization may not be obtained or given while the recipient requesting sterilization is:
(a) in labor or childbirth;
(b) seeking to obtain or obtaining an abortion; or
(c) under the influence of alcohol or other substances that affect the individual's state of mind.

(B) Obtaining Consent.

(1) The person who obtains consent (for example, a physician, nurse, or counselor) must orally inform the recipient requesting sterilization of all of the following:

(a) advice that the recipient is free to withhold or withdraw consent for the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the recipient otherwise might be entitled;

(b) a description of available alternative methods of family planning and birth control;

(c) advice that the sterilization procedure is irreversible;

(d) a thorough explanation of the specific sterilization procedure;

(e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and

(g) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in Subsection (A)(1) above.

(2) The person who obtains consent must also:

(a) offer to answer any questions the recipient may have concerning the sterilization procedure;

(b) give the recipient a copy of the consent form;

(c) make suitable arrangements to ensure that the required information and advice is effectively communicated to any recipient who is blind, deaf, or otherwise handicapped;

(d) provide an interpreter, if the recipient does not understand the language used on the consent form or the language used by the person obtaining consent; and

(e) allow the recipient to have a witness of the recipient's choice present when consent is obtained.

(C) Physician Explanation. Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the recipient of all of the information and advice specified in Subsections (B)(1)(a) through (f) above. The physician's explanation may be made in the facility upon or after admission for the procedure or in the physician's office shortly before admission, but may not be made at the time of initially obtaining recipient consent. The intent of the physician explanation is to offer the recip-

ient a second explanation of sterilization information to ensure that the recipient fully understands the nature and consequences of sterilization.

433.458: Sterilization Services: Consent Form

(A) Required Consent Form. One of the following Consent for Sterilization forms must be used (the distinction between the two forms is made for federal reimbursement purposes only and will not affect the processing of claims made to the Department for sterilization services):

(1) CS-18 -- for recipients aged 18 through 20; or

(2) CS-21 -- for recipients aged 21 or older.

(Instructions for obtaining the Consent for Sterilization forms are in Subchapter 5 of the Physician Manual.)

(B) Completing the Consent Form.

(1) At the time of consent, the consent form must be completed, signed, and dated by:

(a) the recipient;

(b) the interpreter, if one was provided; and

(c) the person obtaining consent. (If the physician is the person obtaining consent, he must sign this statement at the time of consent as well as the physician's statement at a later time.)

(2) After the sterilization procedure is performed, the consent form must be completed, signed, and dated by the physician.

(C) Distributing the Consent Form. The consent form must be completed in triplicate and distributed as follows:

(1) the copy marked "1. Patient" must be given to the recipient at the time of consent;

(2) the copy marked "2. Physician" must be included in the recipient's permanent medical record at the time of admission to the site where the sterilization is performed; and

(3) the copy marked "3. State Agency, Program or Project" must be submitted with the provider's claim to the Department for sterilization services.

(D) Submitting the Consent Form. The physician who performed the sterilization and the hospital, if the sterilization was performed in a hospital, must attach a copy of the completed consent form to their claim forms submitted to the Department for sterilization services. When more than one provider is billing the Department for the same sterilization, photocopies of the completed form may be submitted in lieu of the original.

433.459: Hysterectomy Services

(A) Nonreimbursable Services. The Department will not pay for a hysterectomy provided to a recipient under the following conditions.

(1) The hysterectomy was performed solely for the purpose of sterilizing the recipient.

(2) If there was more than one purpose for the procedure, the hysterectomy would not have been performed but for the purpose of sterilizing the recipient.

(B) Reimbursable Services. The Department will pay for a hysterectomy provided to a recipient only if all of the following conditions are met.

(1) The physician complies with the requirements in Section 433.453 regarding the Department's Consultation Program for Elective Surgery.

(2) The recipient and her representative, if any, are informed orally and in writing that the hysterectomy will render the recipient permanently incapable of reproducing. Delivery in hand to the recipient of the Hysterectomy Information (HI-1) form will fulfill the written requirement, but not the oral requirement.

(3) Before the hysterectomy operation, the recipient or her representative, if any, signs and dates the Hysterectomy Information (HI-1) form, acknowledging receipt of the information required in Subsection (2) above.

(C) Hysterectomy Information Form. Each provider must attach a copy of the completed Hysterectomy Information (HI-1) form to each claim form submitted to the Department for hysterectomy services. When more than one provider is billing the Department for the same hysterectomy, photocopies of the completed form may be submitted in lieu of the original. (Instructions for obtaining the Hysterectomy Information form are in Subchapter 5 of the Physician Manual.)

(106 CMR 433.460 through 433.462 Reserved)

PART 4. REFERRED AND PRESCRIBED SERVICES

433.463: Drugs: Introduction

(A) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for drugs, except as outlined in Subsection (B) below.

(2) For General Relief recipients (category of assistance 04), as required by the General Laws of Massachusetts, only life-sustaining drugs are reimbursable. The Department pays for life-sustaining drugs in the following therapeutic classes for General Relief recipients:

CA--Antineoplastic Agents
OP--Ophthalmic Preparations
04--Antispasmo Anticholinerg
07--Major Tranquilizers
08--Oral Muscle Relaxants
11--Psychostimulants
15--Bronchial Dilators
21--Broad Spectrum Antibiotics
22--Penicillin
24--Sulfonamides
25--Antibiotics Sulfa
27--Other Nonsystemic Antibiotics
28--Urinary Antibacterial Analgesics
31--Amebicides Trichomonas
32--Antimalarials
33--Anthelmintics
34--TB Preparations
39--Antialcoholic
48--Anticonvulsant (including Phenobarbital, Luminal, and Mebaral)
51--Corticoids, Plain and Injectable
55--Thyroid Preparations
56--Antithyroid Preparations
58--Diabetic Therapy
70--Rauwolfias
71--Other Hypotensives
72--Vasodilators Coronary
74--Digitalis Preparations
75--Xanthine Derivatives
76--Other Cardiovascular Preparations
77--Anticoagulants
78--Hemostatics
79--Diuretics
87--Electrolytes and Miscellaneous Nutriments

(B) Service Limitations. The Department will pay for legend drugs except as outlined below. The Department will pay for the nonlegend drugs listed in the Drug and Medical Supply List; this list is sent to pharmacies by the Department.

(1) Methyl Phenidate (Ritalin) and Amphetamines. The Department does not pay for methyl phenidate (Ritalin), amphetamines (including amphetamines in combination), or any other drugs when they are used for control of the appetite. When prescribed for the treatment of hyperkinesis, however, such drugs are reimbursable without prior authorization if the physician writes on the prescription the words "for hyperkinesis" and if the recipient is under 17 years of age. All other uses of amphetamines require prior authorization (see Section 433.465).

(2) Vitamins. The Department pays for vitamins included on the Drug and Medical Supply List only when they are dispensed to infants or children through the age of 36 months or to pregnant women. Plain fluorides are reimbursable when they are dispensed to recipients up to the age of 12 years. General multiple vitamins NF (National Formulary) in a unit of 100 are reimbursable without age restriction.
(3) Iron. The Department pays for only those iron preparations included in the Drug and Medical Supply List.
(4) Immunizing Biologicals and Tubercular Drugs. Immunizing biologicals and tubercular (TB) drugs available free of charge through local boards of public health or through the Massachusetts Department of Public Health are not reimbursable. If the recipient has a prescription, however, the Department will pay for the following drugs for a nonambulatory recipient who cannot attend one of the Department of Public Health clinics: Isoniazid, Myambutal, and P.A.S. All other such drugs require prior authorization (see Section 433.465).
(5) Antacids. The Department pays for antacids only when dispensed to a noninstitutionalized recipient and only if the recipient has gastritis, hiatus hernia, or ulcers.
(6) Laxatives and Stool Softeners. The Department does not pay for laxatives or stool softeners.
(7) Cough and Cold Preparations. The Department does not pay for legend or nonlegend preparations that contain a decongestant, antitussive, or expectorant as a major ingredient when dispensed to a noninstitutionalized recipient.
(8) Propoxyphene. The Department does not pay for any drug product that contains propoxyphene, with the following two exceptions:
(a) propoxyphene hydrochloride 32 mg.; and
(b) propoxyphene hydrochloride 65 mg.
(9) Hexachlorophene Preparations. The Department does not pay for preparations containing hexachlorophene, U.S.P. as the major active ingredient.
(10) Less-Than-Effective Drugs. The Department does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a notice of opportunity for hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications. (Examples of drug products affected by this regulation are listed in Appendix H of the Physician Manual.)

433.464: Drugs: Prescription Requirements

(A) Written Prescription Requirements. Except as provided in Subsection (B) below, legend drugs and nonlegend drugs are reimbursable only after the pharmacy has obtained a written prescription signed by an authorized prescriber. All prescriptions written by prescribers in Massachusetts must be

written on a prescription form approved by the Massachusetts Department of Public Health (Generic Drug Law, M.G.L. c. 112, s. 12D). The prescription must contain the following information:

(1) the recipient's name and address;
(2) the drug name, strength, dosage schedule, and quantity;
(3) the number of authorized refills;
(4) the prescriber's name, address, and Drug Enforcement Administration (DEA) number when available;
(5) the prescriber's signature (preprinted or rubber-stamped signatures are invalid); and
(6) the date on which the prescription was signed by the prescriber.

(B) Waiver of Written Prescription Requirement. Subsection (A) above notwithstanding, an oral/telephone prescription order, as defined in M.G.L. c. 94C, s. 20(c), and containing the information listed in Subsections (A)(1) through (A)(4) above, is recognized as a valid prescription only in the following cases.

(1) The drug prescribed is listed in Schedule VI of the Massachusetts Controlled Substances Act.
(2) For a recipient in a nursing home or rest home: the drug prescribed is listed in Schedule III, IV, V, or VI of the Massachusetts Controlled Substances Act.
(3) The prescriber states that an emergency exists. In an emergency, the drug must be dispensed in compliance with state and federal regulations and in accordance with the following requirements:
(a) the drug quantity may not exceed a 72-hour supply; and
(b) the prescription may not be refilled.
The prescriber must give an original written prescription that conforms with Subsection (A) above to the pharmacy within 72 hours after the oral/telephone order for a drug listed in Schedule II of the Massachusetts Controlled Substances Act, or within seven days after the oral/telephone order for a drug listed in Schedule III, IV, or V of the Massachusetts Controlled Substances Act.

(C) Refills. A prescription may be refilled for the number of times authorized by the prescriber, to a maximum of five refills. No refill may be dispensed after six months from the date of the original prescription. The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

433.465: Drugs: Prior Authorization Requirements

(A) If the limitations for General Relief recipients spe-

cified in Subsection 433.463(A) would result in inadequate treatment for a diagnosed medical condition, the physician may submit a written request for prior authorization to the Department for another drug. The Department will consider a prior authorization request on behalf of a General Relief recipient for only those drugs used to treat a medical condition that may result in long-term functional impairment or immediate pain and suffering if left untreated.

(B) If the limitations on reimbursable drugs specified in Subsection 433.463(B) would result in inadequate treatment for a diagnosed medical condition, the physician may submit a written request for prior authorization for an otherwise nonreimbursable drug.

(C) All prior authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the Physician Manual. If the Department approves the request, it will notify the physician and assign a prior authorization number that must be written on the prescription.

433.466: Durable Medical Equipment and Medical/Surgical Supplies: Introduction

(A) Eligible Recipients. For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) and General Relief recipients (category of assistance 04), the Department pays for the purchase, rental, and repair of durable medical equipment, and the purchase of medical/surgical supplies.

(B) Reimbursable Equipment. Durable medical equipment consists of products that are fabricated primarily and customarily to fulfill a medical purpose, are generally not useful in the absence of illness or injury, can withstand repeated use over an extended period of time, and are appropriate for home use. Payment for durable medical equipment and medical/surgical supplies is considered by the Department on an individual basis.

(C) Nonreimbursable Services.

(1) The Department will not pay for durable medical equipment or medical/surgical supplies that are experimental in nature, unless prior authorization has been obtained.

(2) The Department will not pay for nonmedical equipment or supplies. Equipment that is used primarily and customarily for a nonmedical purpose will not be considered medical equipment, even if such equipment has a medically

related use. For example, equipment whose primary function is environmental control, comfort, or convenience, or that is provided primarily for the comfort or convenience of a person caring for the recipient, or that is customarily used to promote physical fitness is not reimbursable.

(3) The Department will not pay for durable medical equipment or medical/surgical supplies that are not both necessary and reasonable for the treatment of a recipient's medical condition. This includes:

(a) items that cannot reasonably be expected to make a meaningful contribution to the treatment of a recipient's illness or injury or to the improved functioning of a recipient's malformed body member; and

(b) items that are substantially more costly than a medically appropriate and feasible alternative piece of equipment or that serve essentially the same purpose as equipment already available to the recipient.

(4) The Department will not pay for standard medical and surgical treatment products, goods, and health-related items provided to recipients who reside in hospitals, nursing homes, or rehabilitation facilities.

433.467: Durable Medical Equipment and Medical/Surgical Supplies: Prescription Requirements

The purchase or rental of durable medical equipment and the purchase of medical/surgical supplies are reimbursable only when prescribed in writing by a licensed physician. The equipment and repair services must be furnished by a participating Medical Assistance provider. The prescription must include the following information:

(A) the recipient's name, address, 9- or 10-digit card holder number, and 2-digit suffix number;

(B) the specific identification of the prescribed equipment or supplies;

(C) the medical justification for use of the equipment or supplies;

(D) the estimated length of time that the equipment or supplies will be used by the recipient;

(E) the location in which the recipient will customarily use the equipment or supplies;

(F) the physician's address and telephone number; and

(G) the date on which the prescription was signed by the physician.

433.468: Durable Medical Equipment and Medical/Surgical Supplies: Prior Authorization Requirements

The Department requires that the durable medical equipment provider obtain prior authorization as a prerequisite for payment for certain durable medical equipment, including hospital beds and wheelchairs, certain durable medical equipment repair services, and certain medical/surgical supplies. The request for prior authorization must be submitted by the durable medical equipment provider on the appropriate Department form. The physician must complete and sign Sections 1, 2, and 3 of this prior authorization form (see the instructions for requesting prior authorization in Subchapter 5 of the Physician Manual).

433.469: Oxygen and Respiratory Therapy Equipment

(A) Eligible Recipients. For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) and General Relief recipients (category of assistance 04), the Department pays for oxygen and respiratory therapy equipment as defined in Section 433.401.

(B) Nonreimbursable Services.

(1) The Department will not pay for oxygen or respiratory therapy equipment for recipients in acute, chronic, or rehabilitation hospitals, or in state schools.

(2) The Department will not pay for oxygen or respiratory therapy equipment when prescribed for emergency use or on an "as needed" basis for recipients residing in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

(3) The Department will not pay for respiratory therapy equipment that is investigative or experimental in nature, unless prior authorization from the Department has been obtained.

(4) The Department will not pay for nonmedical equipment or supplies. Equipment that is used primarily and customarily for a nonmedical purpose is not considered medical equipment, even if such equipment has a medically related use. For example, equipment whose primary function is environmental control, comfort, or convenience is not reimbursable.

(5) The Department will not pay for oxygen or respiratory therapy equipment that is not both necessary and reasonable

for the treatment of a recipient's pulmonary condition. This includes:

(a) equipment or services that cannot reasonably be expected to make a meaningful contribution to the treatment of a recipient's pulmonary insufficiency; and

(b) equipment or services that are substantially more costly than a medically appropriate, feasible alternative or that serve essentially the same purpose as equipment already available to the recipient.

(C) Prescription Requirements. The purchase of oxygen and the purchase or rental of respiratory therapy equipment are reimbursable only when prescribed in writing by a licensed physician. The oxygen and the respiratory therapy equipment must be furnished by a participating Medical Assistance provider. The prescription must include the following information:

(1) the recipient's name, address, 9- or 10-digit card holder number, and 2-digit suffix number;

(2) the specific identification of the prescribed oxygen and equipment;

(3) the medical justification for the use of the oxygen and equipment;

(4) for oxygen: the prescribed liter flow rate and frequency of treatment;

(5) for respiratory therapy equipment: the frequency of use per day;

(6) the estimated length of time the oxygen or equipment will be used by the recipient;

(7) the location in which the recipient will customarily use the oxygen or equipment;

(8) the physician's address and telephone number; and

(9) the date on which the prescription was signed by the physician.

(D) Purchases and Rentals Requiring Prior Authorization. The Department requires that prior authorization be obtained as a prerequisite to payment for the oxygen and respiratory therapy equipment and services listed below.

(1) Purchase of any of the following requires prior authorization:

(a) respiratory therapy equipment costing more than $35.00; and

(b) gaseous and liquid oxygen provided more than three months after the date of the physician's initial prescription.

(2) Rental of the following requires prior authorization:

(a) gaseous- and liquid-oxygen delivery systems after a rental period of three months;

(b) aspirators after a rental period of three months;
(c) nebulizers after a rental period of three months;
(d) intermittent positive pressure breathing (IPPB) machines after a rental period of three months;
(e) oxygen-generating devices; and
(f) all other rental equipment.

(E) Requests for Prior Authorization. Instructions for the completion of the prior authorization form for oxygen are in Subchapter 5 of the Physician Manual. Before determining the medical necessity of the items or services for which prior authorization is requested, the Department may, at its discretion, require the prescribing physician to submit an assessment of the recipient's pulmonary condition on a patient respiratory evaluation form supplied by the Department.

(1) All prior authorization requests for oxygen and oxygen-generating devices must be accompanied by the results of an arterial blood gas analysis performed within the six weeks preceding the date of the request. This analysis should be performed while the recipient is in a stable chronic condition.

(2) All prior authorization requests for respiratory therapy equipment must be accompanied by the results of a pulmonary function test performed within the six weeks preceding the date of the request.

433.470: Transportation Services

Transportation services are reimbursable only when a recipient is traveling to obtain medical services that are reimbursable under the Medical Assistance Program.

(A) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for transportation services.

(2) For General Relief recipients (category of assistance 04), the Department does not pay for transportation services.

(B) Service Limitations.

(1) Recipients must use transportation resources such as family or friends whenever possible. When personal transportation resources are unavailable, a recipient must use public transportation, if available in his locality and suitable to his medical condition. Private transportation is reimbursable only when public transportation suitable to the recipient's medical condition is unavailable.

(2) In general, the Department will pay for a recipient to

be transported to sources of medical care only within the recipient's locality. Locality refers to the town or city in which the recipient resides and to immediately adjacent communities. However, when necessary medical services are unavailable in the recipient's locality, medical transportation to the nearest medical facility in which treatment is available is reimbursable. If referral outside the recipient's locality is indicated, it is necessary for the physician to supply the recipient's Welfare Service Office with the documentation substantiating this need before authorization can be granted.

(C) Physician Authorization.

(1) Taxi and Dial-a-Ride Transportation. Taxi and dial-a-ride transportation require a prescription written by a physician or dentist on the Prescription for Taxi or Dial-a-Ride Transportation (PT-1) form. (Instructions for obtaining the form are in Subchapter 5 of the Physician Manual.)

(2) Ambulance and Chair-Car Transportation. The physician or the physician's designee who requests an ambulance (on a nonemergency basis) or chair car for a recipient must complete a Medicare/Medicaid Medical Necessity form at the time of the recipient's transfer, stating the specific physical disability that necessitates the requested mode of transportation. If the form is not completed by the physician, the physician's name must be entered on the form where indicated and the authority of the designee must be noted. Information given on the Medical Necessity form must be supported by the recipient's medical record. Emergency ambulance trips do not require a prescription. However, the nature of the emergency must be supported by medical records at the hospital to which the recipient was transported. (Instructions for obtaining the Medicare/Medicaid Medical Necessity form are in Subchapter 5 of the Physician Manual.)

(3) Multiple Trips. When a recipient must travel eight or more times per month to the same destination for a period of two months or more, a physician may authorize all trips for one month (any 30-day period) on one Medical Necessity form. The dates of each trip and the total number of trips must be entered on the form.

(4) Other Forms of Transportation. Other forms of transportation (for example, train, boat, and plane) are reimbursable only if prior authorization is obtained from the recipient's Welfare Service Office or Community Service Area Office.

(D) Recipient Reimbursement. The Department will reimburse a recipient directly for expenses incurred in traveling to

reimbursable medical care only if the recipient's physician, registered nurse, licensed practical nurse, or medical facility social worker documents that reimbursable services were received. The documentation must include the following:

(1) the services that were provided;
(2) the date on which services were provided;
(3) the address where services were provided;
(4) the time services were provided, in cases of urgent medical need; and
(5) a statement that the services could not be obtained locally, if the recipient traveled outside his locality.

433.471: Therapy, Speech and Hearing Clinic, and Amputee Clinic Services

The Department pays for basic restorative services (therapy, speech and hearing clinic, and amputee clinic services) to reduce physical disability and to restore the recipient to a satisfactory functional level. Only those services that have the greatest potential for long-term benefits are reimbursable. The Department will not pay for medically unnecessary or experimental services.

(A) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for restorative services.
(2) For General Relief recipients (category of assistance 04), the Department pays only for restorative services provided in a physician's office; the Department will not pay for restorative services provided by private therapists, clinics, or hospitals.

(B) Physical, Occupational, and Speech Therapy.
(1) Physician Authorization.
(a) Physical and occupational therapy require a written referral from a licensed physician prior to the recipient's evaluation or treatment. The physician's orders for physical and occupational therapy must be renewed in writing every 30 days as long as the recipient is undergoing treatment.
(b) Speech therapy requires the written recommendation of a licensed physician or dentist prior to the recipient's evaluation or treatment.
(2) Service Restrictions. Maintenance therapy is not reimbursable. Only those therapy services that have a specific functional goal are reimbursable.

(C) Speech and Hearing Clinic Services. The recipient must be examined by an ear specialist (an otologist or an

otolaryngologist) before referral is made to a speech and hearing clinic approved by the Department. If a hearing aid is indicated, a medical clearance stating that the recipient has no medical conditions to contraindicate the use of a hearing aid must accompany the referral.

(D) Amputee Clinic Services. An amputee clinic provides the following services: complete medical evaluation of the recipient's need for an artificial limb (prosthetic device); counseling concerning the use of the device; prescription of the device; referral to a certified prosthetic company; and follow-up evaluation. The Department will pay for a prosthetic device only when it is prescribed by an amputee clinic approved by the Department.

433.472: Mental Health Services

This section describes the range of mental health services reimbursable under the Medical Assistance Program.

(A) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for the mental health services described in this section.
(2) For General Relief recipients (category of assistance 04), the Department pays only for psychotherapy provided in a physician's office.

(B) Mental Health Center Services. It is appropriate to refer a recipient to a mental health center when the recipient is no longer able to maintain his level of functioning and must seek professional help. Referral for treatment in a clinic setting is appropriate when the individual is not harmful to himself or to others and can maintain himself in the community even if at a diminished level of functioning.
(1) The Department will pay for mental health center services furnished by free-standing mental health centers, community health centers, hospital-licensed health centers, or hospital outpatient departments only when the Department has certified the provider to perform mental health center services.
(2) Mental health center services are reimbursable only when provided by psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors (with a master's or doctoral degree in counseling education or rehabilitation counseling), or occupational therapists.
(3) Mental health center services include diagnosis and evaluation, case consultation, medication, psychological

testing if done by a licensed psychologist, and individual, couple, family, and group psychotherapy.

(C) Mental Health Practitioner Services. A recipient may be referred to a private mental health practitioner (a licensed physician or a licensed psychologist) for the same reason that he may be referred to a mental health center. Mental health practitioners provide services that are more specialized and less comprehensive than the treatment and support services provided in mental health centers.

(1) The only mental health practitioners who can receive direct payment under the Medical Assistance Program for diagnostic and treatment services are licensed physicians (see Sections 433.425 through 433.427).

(2) The Department will pay licensed psychologists only for providing psychological testing. The Department will not pay psychologists for providing psychotherapy, even under the supervision of a psychiatrist.

(D) Psychiatric Hospital Services. When a psychiatric recipient requires 24-hour management because he may be harmful to himself or to others, or if he is unable to maintain himself in the community, inpatient psychiatric services may be appropriate.

(1) The Department will pay for inpatient psychiatric hospitalization only when provided to:

(a) a recipient 65 years of age or older in a psychiatric hospital participating in the Medical Assistance Program; or

(b) a recipient of any age in a licensed and certified general hospital with or without an inpatient psychiatric unit.

(2) The services of an inpatient psychiatric unit include medication, individual and group therapy, milieu activities, and 24-hour observation provided by an interdisciplinary team.

(E) Psychiatric Day Treatment Services. Some recipients require the structure and support of a psychiatric treatment center, but do not require the overnight care provided by hospitalization. Accordingly, the recipient must have a suitable place to live while attending a psychiatric day treatment program. A psychiatric day treatment program may not adequately meet the needs of actively suicidal, homicidal, severely withdrawn, or grossly confused and disoriented individuals who cannot be maintained by family or friends and who are unable to travel to such a program. The Department will pay for psychiatric day treatment services provided by freestanding mental health centers, hospital-licensed health cen-

ters, hospital outpatient departments, or other facilities only when the Department has certified the provider to perform psychiatric day treatment services.

(106 CMR 433.473 through 433.475 Reserved)

433.476: Alternatives to Institutional Care: Introduction

In recent years, new parts of the Medical Assistance Program have been designed and implemented to help elderly and disabled recipients remain in the community and avoid unnecessary or premature institutional placement. These include home health, adult day health, adult foster care, private duty nursing, independent living, intermediate care for the mentally retarded, and day habilitation. Decisions regarding institutional placement are made by the recipient, his family, his physician, and hospital continuing-care personnel. The physician's role can often be the most influential. For this reason, it is important for the physician to be aware of the alternatives to institutional long-term care. A network of community-based support services that did not exist previously in any quantity or quality is now available in many areas of Massachusetts. Only if physicians become aware of and support the use of such services will the use of institutional services be reduced. For information on services available in your area, contact the Medical Division's Noninstitutional Long-Term Care Unit at the address and telephone number in Appendix A of the Physician Manual.

433.477: Alternatives to Institutional Care: Adult Foster Care

(A) Program Definition. Adult foster care is designed to provide a family-like environment for an adult who otherwise would be in a level II or III nursing home. Each foster family may care for a maximum of two participants (elderly or disabled adults). The foster family provides 24-hour supervision and assistance with such activities of daily living as bathing, dressing, and self-administration of medications. Community support is available from such organizations as certified home health agencies and adult day health programs.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for adult foster care.

(2) For General Relief recipients (category of assistance 04), the Department does not pay for adult foster care.

(C) Physician Responsibilities.

(1) Each recipient must have medical clearance prior to placement in a foster home.

(2) The recipient's physician is required to provide documentation of the following: a physical examination conducted within the preceding three months; current treatment including medications and diet; and a description of any physical or emotional limitations that may preclude participation in activities.
(3) The physician, with the certified home health agency nurses, must maintain follow-up care of the recipient.

433.478: Alternatives to Institutional Care: Home Health Services

(A) Program Definition. Home health agencies provide health and support services in the home for elderly and disabled persons who wish to remain in their homes rather than to enter an institution. These services are available between 8:00 A.M. and 9:00 P.M., and homemaker/home health aide services are available on a 24-hour or short-term basis. All services are available seven days a week. All home health agencies provide nursing and homemaker/home health aide services; in addition, most agencies provide physical, occupational, and speech therapy. The Department pays only Medicare-certified home health agencies, frequently called visiting nurse associations.

(B) Eligible Recipients. For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) and General Relief recipients (category of assistance 04), the Department pays for home health services.

(C) Physician Responsibilities. Any physician who believes that a recipient needs home health services should call the home health agency directly or send written orders. A recipient seen by the agency must have written orders from his physician; these orders must be updated and recertified every 60 days.

433.479: Alternatives to Institutional Care: Private Duty Nursing Services

(A) Program Definition. A private duty nurse is a registered nurse or a licensed practical nurse who independently contracts to provide nursing services to patients who, without such services, might be institutionalized. The Department will pay for nursing care in the recipient's home when private duty nursing services are less costly than institutional placement, provided that the professional services are medically necessary. This program provides alternative care to those home-bound recipients whose medical and nursing needs cannot be met by a home health agency, adult day health program, or support services.

(B) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) not residing in a medical or long-term care facility, the Department pays for private duty nursing services.
(2) For General Relief recipients (category of assistance 04), the Department does not pay for private duty nursing services.

(C) Prior Authorization Requirements. Prior authorization must be obtained from the Department before private duty nursing services are reimbursable. The attending physician and nurse must document the following: diagnoses, treatment plan, functional limitations, estimated length of service, and description of the recipient's social situation.

(D) Physician Responsibilities. The recipient's attending physician must sign the patient care plan documenting the medical necessity for private duty nursing services.

433.480: Alternatives to Institutional Care: Adult Day Health Services

(A) Program Definition. An adult day health program is a structured program of health care and socialization designed to meet the needs of persons who otherwise might be institutionalized. Adult day health services also enable some individuals who have been institutionalized to return to community living. Adult day health programs are based in a center and may be free-standing or located in nursing homes or hospitals. Staff members of the program make arrangements for transportation to and from the center, depending upon community resources and the recipient's needs. The program offers the participant professional supervision, observation, and preventive health care including medical, therapeutic, restorative, counseling, and nutrition services. In addition, the program offers planned educational, recreational, and social activities. These services are provided to maintain the participant at his highest level of functioning, thereby preventing or delaying institutionalization. The program offers the participant's family relief from 24-hour supervision and caretaking. Adult day health programs also provide counseling to family caretakers to help them cope with their family situations.

(B) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for adult day health services.
(2) For General Relief recipients (category of assistance

04), the Department does not pay for adult day health services.

(C) Physician Responsibilities.

(1) Each recipient accepted into an adult day health program must have a complete physical examination within the three months preceding his first program attendance day.

(2) The recipient's physician will be expected to furnish program staff members, upon request, with the results of this physical examination; a list of current medications and treatments; any special dietary requirements; a statement indicating any contraindications or limitations to the individual's participation in program activities; and recommendations for therapy, when applicable.

(3) Each recipient's physician will receive a participant care plan developed by the staff members of the program for review every three months. The program's registered nurse will request that the participant care plan be reviewed and signed by the physician and returned to the program.

433.481: Alternatives to Institutional Care: Independent Living Programs

(A) Program Definition. Independent living programs teach persons with severe physical disabilities the skills to live independently, assisted by a personal care attendant. The skills may be taught in a group residential setting or individually. For those severely disabled persons who have the ability to train and manage a personal care attendant and who are living independently in the community, the program acts as a fiscal conduit to pay the personal care attendant. Participation in this program is helpful to persons to whom a lifetime of institutional or family care is unacceptable.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for independent living program services.

(2) For General Relief recipients (category of assistance 04), the Department does not pay for independent living program services.

(C) Physician Responsibilities. The recipient's physician must certify that his patient is:

(1) severely physically disabled (in need of an average of four hours or more of personal care attendant services per day);

(2) wheelchair dependent for mobility;

(3) emotionally stable; and
(4) medically stable (able to participate in daily living activities without requiring frequent substantial medical care).

433.482: Alternatives to Institutional Care: Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

(A) Program Definition. Community intermediate care facilities for the mentally retarded (or for persons with related conditions) are small community-based residential programs for 15 or fewer residents. There are two types of community ICFs/MR: Type A, serving participants not capable of self-preservation, and Type B, serving ambulatory and mobile nonambulatory participants capable of self-preservation. Both types of facilities provide a planned, 24-hour program of care to persons who are mentally retarded or developmentally disabled. A recipient who participates in a community ICF/MR must be in need of and capable of benefiting from active treatment (for example, a program of regular participation in accordance with an individual plan of care professionally developed and administered by an interdisciplinary team). Treatment is designed to increase the participant's level of functioning and to allow him to become as independent as possible. Participants must have the potential through active treatment to move eventually from the ICF/MR into a setting that is less restrictive.

(B) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for ICF/MR services.
(2) For General Relief recipients (category of assistance 04), the Department does not pay for ICF/MR services.

(C) Physician Responsibilities. The propriety of the recipient's placement in an ICF/MR must be certified by a physician at the time of the recipient's admission and recertified every 60 days. The Massachusetts Department of Mental Health regional or area office screens all potential ICF/MR residents. Physicians who believe that their patients are in need of ICF/MR services should contact the Department of Mental Health area office.

433.483: Alternatives to Institutional Care: Day Habilitation Centers

(A) Program Definition. Day habilitation centers serve persons who are mentally retarded and developmentally disabled and who need more habilitative services than are provided in

less-restrictive day programs but who do not require full-time institutionalization. Day habilitation centers provide a range of intensive medical, behavioral, and therapeutic services in a culturally normative setting. The centers provide goal-oriented services that help participants reach their highest possible level of independent functioning and that facilitate the participants' moving to less-restrictive settings.

(B) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Department pays for day habilitation services.
(2) For General Relief recipients (category of assistance 04), the Department does not pay for day habilitation services.

(C) Physician Responsibilities. The Department screens and refers potential recipients to day habilitation centers with the Massachusetts Department of Mental Health. Any physician who believes that his patient would benefit from day habilitation services should contact the Department of Mental Health area office.

433.484: The Massachusetts Special Education Law (Chapter 766)

(A) Requirement of Law. Chapter 766 of the Acts of 1972 is a comprehensive special education law that requires local school agencies to develop and implement individual educational plans for children with special needs. The law mandates that every child between the ages of three and 21 who has special needs should take part in a special education program. Any child entering kindergarten must have a comprehensive health and developmental examination. Any student between the ages of three and 21 who is having school-related problems will be referred to the school's Administrator of Special Education to obtain all necessary assessments, including medical, psychological, and other specialty evaluations. Based on the results of these assessments, an individualized educational plan will be developed with an emphasis on meeting the needs of the child within the regular classroom setting. In addition, any problems that have been diagnosed must receive treatment.

(B) Payment. Many of the evaluation and treatment services required by the Special Education Law are reimbursable under the Medical Assistance Program. The Department cannot pay for services provided by school personnel. Any services not furnished by Medical Assistance providers, such as educational and social services, that are necessary for an eligible

child's special education, will be furnished or arranged for by the local school agency, as required under Chapter 766.

(1) Individual Medical Assistance Providers. The Department will pay providers for services mandated by the Special Education Law that are furnished to children who are recipients. Payment will be based on the existing fee schedules. For example, the Department will pay for a complete physical examination as required by the law for a kindergarten-aged child if the child is referred to a pediatrician or health clinic that participates in the Medical Assistance Program. As required by the law, a provider who performs any assessments of eligible children after referral by an Administrator of Special Education must submit the reports to the local school agency. The provider must also take the responsibility for treatment of detected conditions.

(2) Medical Assistance Core Evaluation Groups. The Department will pay, at a comprehensive rate, Department-approved interdisciplinary professional groups and Department-approved medical facilities that perform the medical, psychological, and family assessments of a Chapter 766 full core evaluation.

PART 5. PROJECT GOOD HEALTH SERVICES

433.485: Project Good Health Services: Introduction

(A) Legal Basis. Federal law governing Medical Assistance Programs requires the establishment of a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for persons under the age of 21 who are eligible for Medical Assistance (see 42 U.S.C. 1396d(a)(4)(b) and 42 CFR 441.50). Project Good Health (PGH) is the name given to the EPSDT program established in Massachusetts. The Department pays for PGH services provided to Medical Assistance recipients who are under the age of 21, including those who are parents. Sections 433.485 through 433.495 establish the regulations governing physicians who provide PGH services.

(B) Program Objectives. The objectives of PGH are:

(1) to provide to eligible persons comprehensive and continuous health care designed to prevent illness and disability;

(2) to ensure early detection and prompt treatment of health problems before they become chronic or cause irreversible damage; and

(3) to create an awareness of the availability and value of preventive health-care services.

433.486: Project Good Health Services: Definitions

The following definitions apply to PGH services.

(A) Health Assessment -- the provision of screening procedures appropriate to the recipient's age and medical history, as indicated by the Medical Protocol and Periodicity Schedule.

(B) Medical Protocol and Periodicity Schedule -- a schedule (see Section 433.488) developed by the Department in consultation with the Massachusetts Chapter of the American Academy of Pediatrics that consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be carried out. Any deviation from the Medical Protocol and Periodicity Schedule must be documented according to Subsection 433.489(B).

(C) PGH Referral -- a recommendation by the screening physician to a PGH recipient that the recipient return to the screening physician or see another provider for any additional test, diagnosis, or treatment indicated by the screening. The transmission of a specimen to a laboratory does not constitute a referral.

433.487: Project Good Health Services: Provider Cooperation with PGH Specialists

(A) PGH Specialists. PGH specialists are employees of the Department who inform recipients and providers about PGH, assist recipients in scheduling and keeping appointments for health assessments and for further diagnosis and treatment, and follow up to ensure that services have been received.

(B) Provider Cooperation.

(1) Federal law mandates that recipients who have requested assistance in obtaining medical care from the Department or a screening provider receive health assessments, diagnosis, and treatment within defined time periods. To ensure the Department's compliance with these time limits, the PGH specialist must follow up all health assessments the Department has arranged for by obtaining the information listed in Subsections (1)(a) through (c) below. A physician must furnish the following information concerning each claim for PGH services if requested by the PGH specialist in his area:

(a) whether the health-assessment appointment was kept;

(b) whether a referral was made for further diagnosis and treatment; and

(c) if known, the date of the referral appointment.

(2) Once a physician has submitted a claim for PGH services, the physician must furnish health assessments for all recipients referred to him by the Department until that physician notifies the Department's Medical Division in writing that he no longer intends to provide PGH services.

(C) Disclosure Requirement. Recipients must be informed by the physician that information about their medical care will be furnished to the Department.

433.488: Project Good Health Services: Medical Protocol and Periodicity Schedule

Payment for PGH services is based upon the performance and documentation of the procedures listed in the Medical Protocol and Periodicity Schedule herein. The Schedule provides for basic preventive care and identifies recipients who require further diagnosis of suspected or actual health problems, treatment, or both. Explanations of procedures that appear in the Schedule and the information that must be maintained in the medical record to substantiate the performance of such procedures appear below.

(A) (Newborn) Initial History and Physical Examination -- documenting either in the physician's medical record or in the hospital chart an examination of the newborn.

(B) (Newborn) Discharge History and Physical Examination -- documenting either in the physician's medical record or in the hospital chart the discharge history and physical examination of the newborn.

(C) Health History -- recording in the medical record the family health history, baseline data on the recipient if not recorded previously, growth and development history, known reactions to medications and allergies, and pertinent information about previous illnesses, hospitalizations, and other medical and psychosocial problems.

(D) Interval History -- updating previously collected health history in the medical record with any illnesses, diseases, or medical problems experienced by the recipient since his last visit.

(E) Comprehensive Physical Examination -- documenting the findings of an unclothed physical examination including a complete systems review pertinent to the age of the recipient, fundoscopic examination of the eyes for recipients over five years of age, and observation of the teeth and gums for recipients three years of age or older.

(F) Developmental Assessment -- the combined observations by the recipient's parent or guardian and by the physician of the recipient's current levels of functioning in the following areas, as appropriate to the recipient's age:

(1) gross motor development, including strength, balance, and locomotion;
(2) fine motor development, including eye-hand coordination;
(3) language development, including expression, comprehension, and articulation;
(4) self-help and self-care skills;
(5) social interaction and emotional development; and
(6) cognitive skills, including problem-solving and reasoning abilities.

(G) Nutritional Status Assessment -- the evaluation of the recipient's nutritional health in light of dietary practice and the entire health assessment (that is, history, physical examination, height and weight measurements, and laboratory tests) and documentation of any nutritional disturbance or dysfunction.

(H) Appropriate Immunizations -- the administration of injections and serums in accordance with the recommendations of the Massachusetts Department of Public Health and the American Academy of Pediatrics.

(I) Gross Hearing and Vision Tests -- the combined observations by the recipient's parent or guardian and by the physician of the recipient's response to sound and ability to follow moving objects visually.

(J) Blood Pressure -- a standard procedure of the physical examination for recipients three years of age or older.

(K) Hearing Test (Audiometer) -- audiometric testing at the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz.

(L) Vision Test -- testing by the Snellen chart, Titmus machine, or equivalent.

(M) PGH Education and Counseling -- educating and counseling the recipient, or his parent or guardian, in matters appropriate to the recipient's age (for example, nutrition, growth and development, tobacco, drugs, and sexuality).

(N) Assessment of Mental and Emotional Health -- the collaboration by the physician, the recipient's parent or guardian, and the recipient in evaluating the recipient with respect to

the following:

(1) the potential presence of learning disabilities;
(2) peer relations; and
(3) problems, especially depression, in psychological and psychiatric areas.

(O) Pelvic Examination -- documenting the general and specific condition of genitalia and internal reproductive organs. Documentation includes both normal and abnormal findings for the initial pelvic examination and any abnormalities found thereafter.

(P) EP -- the erythrocyte protoporphyrin method of testing for lead poisoning and iron deficiency.

MEDICAL PROTOCOL AND PERIODICITY SCHEDULE

RECOMMENDED AGE

SCREENING PROCEDURES	Newborn	2-6 wks	8-10 wks	4 mos	6 mos	9 mos	1 yr	15 mos	20 mos	2 yrs	30 mos	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10-11 yrs	12-13 yrs	14-15 yrs	16-17 yrs	18-19 yrs	20 yrs
Initial history and physical examination	1																							
Diacharge history and physical examination	1																							
Health history		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
Interval history		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Comprehensive physical exam		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Developmental assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Nutritional status assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Appropriate immunizations		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing/vision tests (gross)		1	1	1	1	1	1	1	1	1	1	1												
Blood pressure												1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing test (audiometer)															4					4				4
Vision test													1			3			4		3			5
PCH education and counseling	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Mental and emotional health status assessment																			1	1	1	1	1	1
Pelvic examination																					9	9	1	1
Hematocrit or hemoglobin							2	1																
EP or blood lead							1	6		3		6		3										
TB test							1								4						3			
Urinalysis and/or culture (if indicated)													1	3	1			1	1	1	1	1	1	1
Cholesterol-if history indicates											1													
Sickle cell test																				7				
Pap smear																					8	8	1	1
GC culture																					9	9	1	1
Serology																					9	9	9	9

Legend

1. The procedure must be done at this age.
2. The procedure must be done if not done previously.
3. The procedure must be done if not done during the last examination age on the schedule.
4. The procedure must be done if not done during the last two examination ages on the schedule.
5. The procedure must be done if not done during the last three examination ages on the schedule.
6. The EP or blood lead test should be performed if the child lives in a city that has a population over 100,000 and if medically necesaary.
7. This procedure should be performed only once and only if indicated by ethnicity.
8. This procedure must be performed if a pelvic examination is performed at this visit.
9. This procedure is optional depending on the maturity level and sexual activity of the recipient.
10. This procedure should be done if appropriate.

433.489: Project Good Health Services: Description of Health Assessments

The health assessments described in this section are reimbursable when provided by a physician or by a nurse practitioner or physician assistant under a physician's supervision.

(A) PGH Health Assessment. A physician may claim payment using Service Code 9020 for a PGH health assessment only if all the screening procedures in the Medical Protocol and Periodicity Schedule that correspond to the recipient's age have been performed. While the screening procedures are based upon a presumption of regular contact with health-care providers, many recipients have infrequent attention paid to their health-care needs and will need additional screening procedures to bring them up to date. In such a case, it is the physician's responsibility to furnish those additional screening procedures necessary to bring the recipient up to date with his preventive health care according to the Medical Protocol and Periodicity Schedule. The physician may make a screening referral to another provider if the physician is unequipped to perform a test (for example, if he does not have an audiometer and an audiometric test is required). However, in every case, all required screening procedures must have been performed and all results received in order for the physician to claim payment for a PGH health assessment.

(B) PGH Health Assessment with Special Circumstances. A physician may claim payment using Service Code 9022 for a PGH health assessment with special circumstances only in the following situations: a screening procedure has been omitted from the health assessment; or the results of laboratory tests or other referred screening procedures were not available within 30 days (see Subsections (1) and (2) below). The Department will review individually all claims for PGH health assessments with special circumstances to determine whether payment will be made. All claims for such health assessments based on the omission of a medically unnecessary screening procedure will be reviewed by a physician.

(1) Omission of a Procedure. A physician may omit a procedure from a health assessment only in the following situations.

(a) Procedure Was Not Medically Necessary. If a physician omitted a screening procedure from a PGH health assessment because, in his professional judgment, the procedure was not medically necessary, the physician must include with the claim for payment a statement citing the omitted procedure and the reason that it was

not medically necessary. If the procedure was omitted because it was performed earlier, the date of such procedure must be included in the statement. For the purposes of this subsection, nonperformance of a procedure in the Medical Protocol and Periodicity Schedule that has the legend number 6, 7, 8, 9, or 10 corresponding to the recipient's age is not considered to be an omission, since such nonperformance is based upon factual determination rather than medical judgment.

(b) Procedure Was Impossible to Perform. If a physician omitted a screening procedure from a PGH health assessment because it was impossible to perform, the physician must include with the claim for payment a statement citing the omitted procedure and the reason that the procedure was impossible to perform. If the procedure was impossible to perform because the recipient refused to cooperate, the physician must describe in the statement his efforts to overcome the problem.

(2) Results of Referred Screening Procedure Not Available within 30 Days. If a physician did not know the results of a laboratory test or other referred screening procedure within 30 days after the health assessment, the physician must include with the claim for payment a statement that the laboratory or other provider has not returned the results and citing which results are outstanding.

433.490: Project Good Health Services: Dental Care

The screening physician must encourage the recipient to seek regular dental care, including annual examinations, preventive services, and treatment as necessary, from a dental provider. The Department will inform recipients three years of age or older, or their parents or guardians, about available dental care and will offer assistance in scheduling and keeping appointments with dental providers.

433.491: Project Good Health Services: Diagnosis and Treatment

(A) For any problem that requires further diagnosis or treatment after the health assessment, the physician either must request that the recipient return for another appointment or must refer the recipient to another provider. Federal regulation mandates the time limits within which screening, diagnosis, and treatment must be performed. Therefore, the request or the referral must be made immediately or as soon as the physician obtains the screening result indicating a need for referral.

(B) When making a referral to another provider, the screening physician must give to the recipient or to the recipient's

parent or guardian the name and address of an appropriate provider.

(C) The screening physician must establish a procedure to obtain a report of the results of diagnosis and treatment.

(D) If a physician knows of any reason that a recipient might not make or keep an appointment for further diagnosis and treatment, such as a need for transportation, translation, or child care, the physician must contact the PGH specialist in his area for assistance. For a list of locations and telephone numbers of PGH specialists, see Appendix G of the Physician Manual.

433.492: Project Good Health Services: Claims for Health Assessments

(A) Fees for Health Assessments. The service codes and descriptions in Subsection (E) below were adopted by the Massachusetts Rate Setting Commission for PGH health assessments furnished in accordance with the Medical Protocol and Periodicity Schedule and with these PGH regulations.

(B) Service Limitations. For each recipient from birth through nine years of age, a physician may claim only one health assessment per age level in the Medical Protocol and Periodicity Schedule. For each recipient aged ten years through 20 years, a physician may claim only one health assessment per year. Additional visits for high-risk recipients are not considered to be PGH health assessments but are reimbursable according to the office visit service codes and descriptions in Section 433.414.

(C) Claims for Health Assessment of a Newborn. In order to be paid for a PGH health assessment of a newborn, the physician must have visited the newborn at least twice before the newborn leaves the hospital. The first visit, for an initial history and physical examination, is reimbursable as a hospital inpatient visit (see Section 433.417) and not as a PGH health assessment. The discharge visit, for a discharge and physical examination, is reimbursable as a PGH health assessment, in accordance with Subsections (D) and (E) below. Additional visits for ill newborns are reimbursable according to the hospital visit service codes in Section 433.417.

(D) Report Requirement. In order to claim payment for a PGH health assessment, a physician must submit a completed PGH/EPSDT Claim Form and Medical Examination Report (MA-7P). The MA-7P is a form specifically designed to collect written documentation of the screening procedures provided and each

result, including problems needing follow-up treatment, as required by federal EPSDT regulations. Instructions for obtaining and completing the MA-7P form are in Subchapter 5 of the Physician Manual.

(1) When submitting a claim for a health assessment with special circumstances, the physician must attach his statement (see Subsection 433.489(B)) to the MA-7P form. (See the billing instructions in Subchapter 5 of the Physician Manual.)

(2) If a nurse practitioner or physician assistant has performed the health assessment, this must be indicated in the appropriate space on the MA-7P form (see the billing instructions in Subchapter 5 of the Physician Manual).

(E) Service Codes and Descriptions.

Service Code	Service Description
9020	PGH health assessment (MA-7P form required)
9022	PGH health assessment with special circumstances (MA-7P form required) (medical review)

433.493: Project Good Health Services: Claims for Laboratory Services

The following laboratory services, which are included in the Medical Protocol and Periodicity Schedule, are reimbursable in addition to the health assessment when performed in the office of the physician who furnished the health assessment. A physician may not claim payment for any test until the results are known.

Service Code	Service Description
108112	Cholesterol, total
108665	Culture, GC (gonococcus culture)
108885	Culture, routine, any source
108379	Erythrocyte protoporphyrin*
108368	Hematocrit (HCT)
108366	Hemoglobin (HGB), colorimetric
108260	Lead screening, blood*

*Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

108920 Pap (Papanicolaou) smear; cytopathology smear; Gravlee jet washing

108653 Serology; rapid plasma reagin (RPR)

108442 Sickle cell preparation

108340 Triglycerides, blood

108708 Urinalysis, complete (includes dip stick and microscopic exam and specific gravity)

108873 Urinary dip stick (pH, blood, ketones, glucose, nitrites) per combination dip stick

433.494: Project Good Health Services: Claims for Audiometric Hearing Test

Payment for the audiometric hearing test, which is included in the Medical Protocol and Periodicity Schedule, is not included in the fee for a health assessment and should be claimed separately according to the service code below.

Service Code	Service Description
9350	Audiometric hearing test, pure-tone, air only

433.495: Project Good Health Services: Recordkeeping Requirements

(A) Medical Records. A physician must create and maintain a centralized record for every PGH recipient in his care, in accordance with Department regulations governing medical records generally (see Section 433.409). In addition, the record for each PGH recipient must contain documentation of the screening procedures listed in Subsections 433.488(A) through (P) as well as the following:

(1) the results of all laboratory tests;
(2) the name and address of each referral provider; and
(3) the date and results of each referral appointment, if the appointment was kept.

(B) Determination of Compliance with Medical Standards. The Department may review a physician's medical records of PGH

recipients to determine the necessity, propriety, and quality of the medical care furnished. These determinations will be made by medical professionals in accordance with 106 CMR 450.206. The Department may request review by the Massachusetts Chapter of the American Academy of Pediatrics, or other appropriate professional organization, for the purposes of making such determinations. This review will be considered before the Department proceeds with administrative action based on a determination of noncompliance with medical standards as defined in 106 CMR 450.204.

(106 CMR 433.496 through 433.600 Reserved)

433.601: Laboratory Service Codes and Descriptions

(A) Individual Tests.

Service Code	Service Description
108477	ABO and Rh genotype
108476	ABO grouping
108055	Acetone, serum
108710	Acetone, urine
108886	Acid fast culture
108882	Acid fast direct smear (concentrated AF smear, sputum)
108293	Acid phosphatase
108200	ACTH, adrenocorticotropin by RIA
108707	Addis count (quantitative sediment analysis)
108981	Agar plate--sweat electrolytes, qualitative
108460	Agglutination febrile per antigen
108486	Agglutinins, cold
108062	Albumin, chemistry
108712	Albumin, qualitative, urine
108711	Albumin, quantitative (Esbach)
108063	Alcohol, ethyl, methyl, isopropyl
108067	Aldolase
108767	Aldosterone, urine, RIA
108797	Aldosterone secretory rate
108295	Alkaline, phosphatase (blood)
108296	Alkaline, phosphatase; fractionated (isoenzymes) (electrophoresis)

108427	Alkaline, phosphatase stain leucocyte
108081	Alpha 1 antitrypsin
108718	Amino acid, urine chromotographic fractionation and quantitation
108074	Ammonia, quantitative
108969	Amniocentesis, spectrographic analysis
108079	Amniotic fluid surfactant shake test
108721	Amylase (diastase), urine
108075	Amylase, chemistry
108899	Anaerobic culture (neg.)
108220	Angiotensin, blood
108510	Antibodies, heterophile screening (includes mono-type test)
108467	Antibody, irregular identification
108523	Antibody, thyroglobulin or microsomal
108406	Anticoagulants, circulating
108133	Anticonvulsive blood panel by GLC (dilantin and phenobarbitol)
108470	Antideoxyribonuclease titer (DNA)
108462	Antimitochondrial antibodies (AMA)
108077	Antinuclear fluorescent antibodies (ANA)
108483	Anti Rh immunoglobulin testing (RhoGam type)
108956	Antismooth muscle antibody (ASMA)
108473	Antistreptolysin titer, ASO, ASOT, AST, ASL
108724	Arsenic quantitative, urine
108167	Arterial blood by electrode and pO_2, pOO_2

108080	Ascorbic acid; vitamin C
108463	Autoantibody screening
108352	B_{12} vitamin
108084	Barbiturates, blood quantitative (GLC)
108083	Barbiturates, urine screen
108369	Basophil count
108215	Beta sub unit
108089	Bicarbonate
108604	Bile, fecal
108730	Bile pigments, urine
108088	Bilirubin, direct
108087	Bilirubin, total and fraction
108360	Bleeding time
108363	Blood count (RBC)
108364	Blood count (WBC)
108365	Blood count, differential
108884	Blood culture
108372	Bone marrow (interpretation only)
108092	Bromide
108330	Bromsulphophthalein (BSP)
108924	Buccal smear for chromosomal sex determination (Barr)
108367	Buffy coat smear
108344	BUN; urea nitrogen
108536	C-1 esterase inhibitor
108537	C-3 complement

108538	C-4 complement
108093	Calcium, blood chemistry
108098	Calcium determination, ionized
108736	Calcium, qualitative, urine
108737	Calcium, quantitative, urine
108680	Calculus analysis, qualitative, chemical
108099	Carbon dioxide, chemistry
108154	Carbon dioxide content or combining power
108100	Carbon monoxide, blood
108507	Carcinoembryonic antigen (CEA) by radioimmunoassay
108101	Carotene, beta
108771	Catecholamines, fractionated, urine
108770	Catecholamines, urine, total
108361	CBC: complete blood count (includes differential, RBC, hematocrit, hemoglobin, white blood count, and indices)
108507	CEA: carcinoembryonic antigen radioimmunoassay
108926	Cell block
108952	Cell count and differential
108951	Cell count, miscellaneous body fluids, except blood (e.g., CSF, joint, etc.)
108103	Ceruloplasmin
108640	Chlorides, spinal fluid
108742	Chlorides, urine
108110	Chlorides, chemistry
108113	Cholesterol, ester
108112	Cholesterol, total

108114	Cholinesterase
108927	Chromosome analysis (karyotype)
108406	Circulating anticoagulants
108378	Clot retraction
108403	Coagulation time; L and W
108486	Cold agglutinin
108648	Colloidal gold
108361	Complete blood count (CBC) (includes WBC, RBC, hemoglobin, hematocrit, and differential indices)
108120	Congo red
108500	Coombs, direct
108501	Coombs, indirect qualitative
108121	Copper, serum
108746	Copper, urine
108799	Cortisol, plasma
108801	Cortisol, secretory rate
108129	CPK, isoenzyme
108485	C-reactive protein (CRP)
108122	Creatine, blood
108747	Creatine, urine
108123	Creatine phosphokinase (CPK)
10825	Creatinine, chemistry
108126	Creatinine clearance
108748	Creatinine, urine
108475	Crossmatch

108128	Cryoglobulin
108886	Culture acid fast, A.F.
108899	Culture anaerobic (neg.)
108889	Culture "B" strep throat
108884	Culture, blood
108887	Culture, fungus
108665	Culture, G.C. (gonococcus culture)
108885	Culture, routine, any source
108897	Culture and sensitivity, antibiotic
108898	Culture, sensitivity, and colony count
108888	Culture, urine (quantitative) with colony count
108130	Cyanide
108750	Cystine screening, qualitative
108923	Cytopathology, fluid
108920	Cytopathology smear; Papanicolaou (Pap) smear; Gravlee jet washing
108922	Cytopathology smears other than genital
108905	Dark field examination
108752	Delta-amino-levulinic acid (ALA), urine
108761	Diacetic acid, qualitative, urine
108635	Diagnex blue, gastric analysis, tubeless
108721	Diastase, amylase, urine
108365	Differential blood count
108131	Digoxin, RIA
108132	Dilantin quantitative, blood (diphenylhydantoin)

108873	Dip stick, urine (pH, blood, ketones, glucose, nitrites) per combination dip stick
108605	Direct wet preparation
108470	DNA (antideoxyribonuclease titer)
108134	Doriden (glutethimide)
108995	Drawing of specimen by independent laboratory, per recipient visit
108408	Eosinophil count (EOS)
108379	Erythrocyte protoporphyrin
108316	Estradiol by RIA
108214	Estriol, blood
108783	Estrogens, urine, fractionated into estrone, estradiol, and estriol
108782	Estrogens, urine total, nonpregnant state
108320	Fasting blood sugar (FBS); glucose; sugar
108602	Fat, fecal or lipids (stain)
108135	Fatty acids, blood
108460	Febrile agglutination, per antigen
108954	Ferritin
108411	Fibrin (split products) (FSP)
108390	Fibrin stabilizing, factor XIII
108412	Fibrinogen, qualitative (F-Y test)
108413	Fibrinogen, quantitative
108534	Flocculation, STS (standard test for syphilis)
108893	Fluorescent beta strep. screening
108563	Fluorescent treponema antibodies, absorbed (FTA)

108138	Folic acid, vitamin M (folate level)
108795	Follicle stimulating hormone (FSH) by RIA; urinary pituitary gonadotropins
108332	Free thyroxine (includes thyroxine T_4)
108943	Frozen section
108887	Fungus culture
108140	Galactose
108146	Gamma-glutamyl transpeptidase (GGTP)
108635	Gastric analysis, tubeless, diagnex blue
108631	Gastric analysis without histamine, routine
108984	Gastrin serum by RIA
108665	GC culture (gonococcus culture)
108179	Globulin, direct determination
108642	Glucose, spinal fluid
108320	Glucose; sugar; postprandial sugar; fasting blood sugar (FBS)
108864	Glucose; sugar, quantitative, 24-hour specimen
108322	Glucose tolerance (maximum of five assays)
108176	Glucose 6-phosphate-dehydrogenase (G-6-PD) quantitative
108175	Glucose 6-phosphate-dehydrogenase (G-6-PD) screen
108134	Glutethimide (doriden)
108976	Glycohemoglobin (Ha AIC)
108794	Growth hormone, GH or HGH, by RIA
108908	Guinea pig or small animal inoculation
108182	Haptoglobin
108725	Heavy metal, Reinsch test

108368	Hematocrit (HCT)
108765	Hemogentistic acid screen
108190	Hemoglobin electrophoresis, starch block
108183	Hemoglobin electrophoresis, paper or cellulose acetate
108196	Hemoglobin CO, methemalbumin, methemoglobin spectroscopic
108186	Hemoglobin F (fetal) (chemical)
108366	Hemoglobin (HGB), colorimetric
108508	Hepatitis associated antigen (HAA, HBsAg)
108978	Herpes simplex titer
108510	Heterophile: antibodies, screening (includes mono-type test)
108513	Heterophile exclusion
108794	HGH growth hormone (GH) by RIA
108241	High-density lipoprotein (HDL)
108474	HLA B-27
108996	Home/nursing home visit by independent laboratory, first recipient seen
108997	Home/nursing home visit by independent laboratory, each additional recipient seen
108765	Homogentistic acid screen, urine
108236	Hydroxybutyric dehydrogenase (HBD)
108787	Hydroxycorticosteroids, reduced ketogenic Porter-Silber
108860	5-Hydroxyindoleacetic acid (5-HIAA), quantitative; serotonin
108810	Hydroxyproline, urine, free
108811	Hydroxyproline, urine, total
108812	Hydroxyproline, urine, free and total

108517	Immunodiffusion (IGg, IgA, IgE, IgM, IgD) (maximum of three tests)
108515	Immunoelectrophoresis
108222	Insulin, blood
108326	Insulin tolerance (includes injection)
108225	Iodine, butanol extractable (BIE, BEI)
108224	Iodine, protein bound (PBI)
108226	Iodine, urine
108098	Ionized calcium determination
108242	Iron
108246	Iron binding capacity, Irosorb (TIBC) (includes iron)
108424	Iron stain
108467	Irregular antibody identification
108129	Isoenzyme, CPK
108955	Joint fluid analysis, mucin test; ropes
108785	17-Ketogenic steroids
108790	17-Ketosteroids, total
108255	Lactic dehydrogenase (LDH)
108257	Lactic dehydrogenase isoenzyme; electrophoresis
108520	Latex fixation, RA
108522	Latex fixation, rheumatoid factor
108260	Lead screening, blood*
108816	Lead screening, urine*
108525	L.E. preparation, smear method
108263	Leucine aminopeptidase (LAP), blood

*Send to: State Lead Poison Prevention Program
305 South Street
Jamaica Plain, MA 02130

108818	Leucine aminopeptidase (LAP), urine
108427	Leucocyte alkaline phosphatase stain
108265	Lipase
108602	Lipids or fat (stain)
108266	Lipids, total
108268	Lipoproteins (electrophoresis)
108270	Lithium, blood, quantitative
108525	Lupus erythematosus; LE preparation (smear method)
108219	Luteinizing hormone, blood (LH)
108271	Magnesium, blood
108275	Manganese, blood
108826	Mercury, screening, urine
108828	Metanephrine
108196	Methemalbumin, hemoglobin CO, methemoglobin spectroscopic
108523	Microsomal antibody or thyroglobulin antibody
108282	Mono test (rapid screening)
108269	Myoglobin electrophoresis
108833	Myoglobin screening
108957	Mysoline serum level (primidone)
108284	Nonprotein nitrogen (NPN)
108283	Nucleotidase
108600	Occult blood

108705	Occult blood, urine
108286	Osmolality
108437	Osmotic fragility, red blood cell, incubation
108606	Ova and parasites
108837	Oxalates, urine
108920	Pap (Papanicolaou) smear; cytopathology smear; Gravlee jet washing
108237	Parathyroid hormone (PTH) (parathormone)
108450	Partial thromboplastin time (PTT)
108152	pCO_2 (gases)
108150	pH^1 (gases)
108843	Phenolsulfonphthalein (PSP), urine
108293	Phosphatase acid
108295	Phosphatase alkaline, blood
108296	Phosphatase alkaline, fractionated (isoenzymes) (electrophoresis)
108123	Phosphokinase, creatine (CPK)
108298	Phospholipids, blood
108300	Phosphorus
108607	Pin worm exam, Scotch tape, etc.
108206	Pituitary gonadotropins, blood, by RIA
108795	Pituitary gonadotropins, urinary (FSH), by RIA
108218	Plasma renin assay (renin, blood)
108433	Platelet adhesiveness
108446	Platelet aggregation screening
108430	Platelet count (Rees-Ecker)

108165	pO_2 (gases)
108167	pO_2, pOO_2, and arterial blood by electrode
108850	Porphobilinogen
108852	Porphyrins, quantitative, including coporphyrin, uroporphyrin, and porphobilinogen
108301	Potassium (K), blood
108853	Potassium (K), urine
108881	Potassium hydroxide, wet mount, any source
108202	Pregnancy test, tube (U.C.G.)
108209	Pregnancy test, slide
108796	Pregnanediol, urine (chemical)
108800	Pregnanetriol, urine (chemical)
108957	Primidone (mysoline serum level)
108217	Progesterone, blood
108983	Prolactin
108302	Pronestyl
108855	Protein, Bence-Jones, urine
108224	Protein bound iodine (PBI)
108485	Protein, C-reactive (CRP)
108305	Protein, electrophoresis
108645	Protein, quantitative, spinal fluid
108303	Protein, total
108434	Prothrombin time (activity) (PT)
108435	Prothrombin utilization (consumption)
108312	Quinidine, blood

108653	Rapid plasma reagin (RPR); serology
108398	Recalcification time
108437	Red blood cell, osmotic fragility, incubation
108363	Red blood count (RBC)
108436	Red cell fragility (Rumpel-Leede osmotic Sanford)
108218	Renin, blood (plasma renin assay)
108440	Reticulocyte count
108464	Rh titer, A, B and others, albumin or saline technic, each
108480	Rh typing
108520	Rheumatoid arthritis (RA); latex fixation
108483	RhoGam type (anti Rh immunoglobulin testing)
108530	Rubella, C-F test, single test
108528	Rubella, H.I., acute and convalescent (two tests, same recipient)
108527	Rubella, H.I., single sample
108313	Salicylates, blood
108858	Salicylates, quantitative
108707	Sediment analysis, Addis count, quantitative
108441	Sedimentation rate; erythrocyte sedimentation rate (ESR); Wintrobe
108975	Semen analysis, complete (volume count, motility, differential)
108973	Semen analysis (including Huhner)
108897	Sensitivity and culture, antibiotic
108898	Sensitivity, culture, and colony count
108653	Serology; rapid plasma reagin (RPR)

108860	Serotonin; 5-hydroxy-indoleacetic acid (5-HIAA), quantitative
108335	SGOT transaminase
108337	SGPT transaminase
108442	Sickle cell preparation
108882	Smear, acid fast (AF), sputum, concentrated specimen
108654	Smear for bacteria (spinal fluid)
108924	Smear, buccal for chromosomal sex determination (Barr)
108367	Smear, buffy coat
108922	Smear, cytopathology, other than genital
108880	Smear, routine (initial miscroscopic examination)
108920	Smear, Pap (Papanicolaou); cytopathology smear; Gravlee jet washing
108862	Sodium (Na)
108863	Specific gravity, any method, urine
108882	Sputum smear (acid fast smear)
108889	Strep throat culture "B"
108534	S.T.S. flocculation (standard test for syphilis)
108937	Surgical pathology, multiple specimens and/or extensive dissection with individual identification or unusual preparation
108936	Surgical specimen, gross
108934	Surgical specimen, gross and microscopic exam, per specimen
108981	Sweat electrolytes, qualitative agar plate
108980	Sweat electrolytes, quantitative sodium and chloride
108227	T-3 total (tri-iodo-thyronine)

108331	T-4 (thyroxine)
208324	Tegretol
108223	Testosterone, blood
108447	Thromboplastin generation time test (TGT); Hicks-Pitney test
108523	Thyroglobulin antibody or microsomal antibody
108233	Thyroid binding globulin
108234	Thyroid stimulating hormone (TSH)
108332	Thyroxine, free (includes thyroxine T_4)
108325	Tolbutamide tolerance (includes injection) (maximum of 5 assays)
108560	Toxoplasmosis test
108335	Transaminase SGOT
108337	Transaminase SGPT
108340	Triglycerides, blood
108613	Trypsin, fecal
108234	TSH (thyroid stimulating hormone)
108202	UCG (pregnancy test, tube)
108999	Unlisted test (I.C.)
108346	Urea clearance
108344	Urea nitrogen, blood (BUN)
108872	Urea nitrogen or uric acid; urine
108347	Uric acid, blood (SUA)
108708	Urinalysis, complete (includes dip stick and microscopic exam and specific gravity)
108873	Urinary dip stick (pH, blood, ketones, glucose, nitrites) per combination dip stick

108877	Urobilinogen, qualitative (Ehrlich test), urine
108876	Urobilinogen, quantitative (Watson), urine
108773	Vanilly-mandelic acid, quantitative, chromotographic (VMA)
108666	VDRL
108352	Vitamin B_{12}
108080	Vitamin C; ascorbic acid
108138	Vitamin M; folic acid (folate level)
108364	WBC; white cell count
108881	Wet mount, any source, potassium hydroxide
108355	Xylose, tolerance test (blood)
108358	Xylose, urine
108878	Zinc
108356	Zinc, tolerance test, blood

(B) Profile Tests.

(1) "List A" Profiles. When one or two of the tests listed here are performed as individual (bench) tests, the physician may bill according to the service code for the individual test (see Subsection 433.601(A)). However, when three or more of these tests are performed as a profile (as defined in Subsection 433.401(X)), the physician must bill according to the service codes below, except for an electrolyte profile (Service Code 108036), which may be billed as an "other profile". If one or more tests in the profile are not in the list below, but are in the service codes and descriptions of individual tests (see Subsection 433.601(A)), the maximum allowable fee is the sum of the maximum allowable fee for the profile plus the maximum allowable fees for the individual tests listed in Subsection 433.601(A).

List A

(Note: The following profiles are frequently composed of tests in List A and should be billed for accordingly: cardiac profile, cerebral spinal fluid profile, hypertension

screen, lipid profile, liver function profile, and renal profile.)

Albumin	Iron
Alkaline phosphatase	LDH
Bilirubin, total and direct	Phosphorus
BUN (urea nitrogen)	Potassium
Calcium	SGOT
Chloride	SGPT
Cholesterol	Sodium
CO_2	Total protein
Creatinine	Triglycerides
Globulin	Uric acid
Glucose	

Service Code	Service Description
108004	3 through 7 tests
108008	8 through 12 tests
108013	13 through 17 tests
108018	18 tests and over

(2) Other Profiles. These profiles must be billed as a group, whether they are performed manually or automatedly (see Subsection 433.439(D)).

Service Code	Service Description
108026	Bone/joint Calcium Phosphorus RA latex screen Sedimentation rate Uric acid
108361	Complete blood count (CBC) Hemoglobin Hematocrit White blood count Differential Red blood count
108036	Electrolytes Chlorides Potassium CO_2 Sodium

108042 Lipoprotein phenotyping
- Cholesterol
- Triglycerides
- Lipoprotein electrophoresis and phenotyping

108034 Premarital
- Serology
- Rubella

108027 Prenatal
- Blood group and Rh factor
- CBC
- Rubella antibody
- RPR
- Antibody screen

108046 Rheumatoid
- ASO titer
- C-reactive protein
- Antinuclear antibodies
- Latex fixation
- Uric acid

108048 Thyroid
- T_3-uptake
- T_4
- Free thyroxine index

108598 Radio allergy absorbent test (RAST)
- Cat epithelium
- Dog epithelium
- Egg white
- Giant ragweed
- Home dust
- Milk
- Penicillium notatum
- Timothy
- Yeast

433.602: Radiology Service Codes and Descriptions

Service Code	Service Description
	X-RAY DIAGNOSTICS
	Head and Neck
7000	Pneumoencephalography with preliminary skull films

7001	Dacroystogram
7002	Larynogram
7003	Echoencephalography
7005	Ventriculography with preliminary skull films
7008	Eye determination of foreign body
7009	Eye localization of foreign body
7014	Mandible, unilateral, two views
7015	bilateral, more than two views
7020	Mastoids, less than four views
7021	minimum four views
7025	Facial bones, orbits, unilateral
7026	bilateral, minimum three views
7030	Nasal bones, three views minimum
7039	Optic foramina
7049	Paranasal sinuses, four views minimum
7054	Skull, paranasal sinuses, or sella turcica, single view
7059	Skull or sella turcica, two through four views
7060	Skull with stereo as indicated, minimum five views (complete study)
7070	Temporomandibular joints, open and closed, unilateral
7071	bilateral
7077	Neck, soft tissues examination

7080	Larynx and hypopharynx
7085	Salivary gland for calculus
7088	Sialogram, unilateral
7089	bilateral

Chest

7101	Chest, single view
7102	P.A. and lateral view, two views
7103	multiple views, three or more
7105	Chest, multiple views with fluoroscopy (complete chest)
7130	Bronchography, unilateral
7131	bilateral
7150	Ribs, unilateral, minimum three views
7151	bilateral, minimum five views
7170	Sternum, two views minimum
7175	Sternoclavicular joints, three views minimum

Spine and Pelvis

7200	Spine, entire, survey study, A.P. and lateral each area
7205	cervical, A.P. and lateral, two views
7210	thoracic, A.P. and lateral, two views
7211	thoraco-lumbar (lower thoracic, upper lumbar) two views
7212	lumbar, A.P. and lateral
7213	lumbosacral
7217	Scoliosis survey, fusion or leg length integrity
7220	Pelvis and hips or sacroiliac study, one view only
7221	One A.P. view of pelvis and both hips with any of the above spinal X rays

7222 Stereo, any part of the spine or pelvis, two views with any of the above X rays

7223 Obliques, any part of the spine or pelvis, two views with any of the above spinal X rays

7225 Flexion and extension, any part of spine, two views with any of the above spinal X rays

7226 Bending views, any part of spine, one projection, two views

7227 Pelvis or sacroiliac joints, minimum three views

(For pelvimetry, see Service Code 7390.)

7228 Sacrum and/or coccyx

7230 Myelography

Upper Extremities

7260 Acromioclavicular joints, clavicle, scapula, or shoulder, one view

7261 two views

7265 three or more views, with or without distraction

7270 Humerus, routine study

7276 Elbow, routine study

7280 Forearm, routine study

7286 Wrist, routine study

7290 Hand or fingers, routine study

7291 Hand and wrist, routine study

7292 Navicular views

7293 Comparison study of any of the above at same sitting

Lower Extremities

7300	Hip, one view
7301	A.P. and lateral
7302	during operative procedure, up through four views
7303	during operative procedure, each additional study over four
7304	Hip and/or pelvis, routine study
7308	Femur (thigh), including one joint
7309	shaft, A.P. and lateral
7310	Knee, routine study
7311	tunnel or subpatella study, routine study
7315	Tibia and fibula (lower leg), routine study
7316	Leg, including one joint
7319	Ankle, routine study
7323	Foot and/or toes, routine study, minimum three views
7324	Foot, including special os calcis view
7326	Os calcis (heel), routine study
7327	Foot and ankle, routine study
7328	Comparison study of any of the above at same sitting

Abdomen

All fees in this section include an allowance for a K.U.B. or flat plate of the abdomen.

7329	Ultrasound, abdomen (includes technical and professional component)
7330	Abdomen, single view (I.P.)
7331	multiple views (I.P.)

7333 special studies such as passage of Miller-Abbot tube, fluoroscopy only (no films) (I.P.)

7334 Ultrasound, abdomen (professional component only)

7336 Ultrasound, abdomen, follow-up exam (includes technical and professional component)

7338 Ultrasound, abdomen, follow-up exam (professional component only)

Gastrointestinal Tract

7335 Esophagus and/or pharynx (I.P.)

7337 Upper gastrointestinal examination

7339 Upper gastrointestinal and small bowel examination

7341 Small bowel examination (separate study) with or without fluoro or K.U.B.

7344 Colon examination, barium enema

7345 barium enema plus double contrast exam, same day

7346 double contrast examination as principal procedure

7348 Cholecystography, oral

7350 Cholangiography, operative, interpretation only

7351 postoperative, through T-tube

7352 intravenous

7353 Upper G.I. double contrast exam

7354 Hypotonic duodenography (I.P.)

Urological

The maximum allowable fees for the services in this section include an allowance for a K.U.B. or flat plate of the abdomen.

7360 Abdomen (K.U.B.), single view (I.P.)

7361 multiple views (I.P.)

7363	Urography, intravenous, routine
7364	special hypertensive study
7365	Pyelography, retrograde
7366	Urography, drip infusion intravenous
7368	Cystography or incontinence study
7371	Urethrocystography, retrograde
7372	voiding
7378	Perirenal insufflation retroperitoneal pneumography

Gynecological and Obstetrical

(For abdomen and pelvis, see Service Codes 7220 through 7227, 7330, and 7331.)

7390	Pregnancy with pelvic measurements
7393	Hysterosalpingogram (utersalpinography)
7394	Ultrasound, obstetrical (includes technical and professional component)
7396	Ultrasound, obstetrical (professional component only)
7397	Ultrasound, obstetrical, follow-up exam (includes technical and professional component)
7399	Ultrasound, obstetrical, follow-up exam (professional component only)
7395	Seminography

Vascular System

7480	Angiography, serial study
7481	Angiography, single film study
7484	Venography

Miscellaneous

7524	Fluoroscopy only
7554	Bone age studies
7555	Bone length studies
7556	Ultrasound, M-mode (includes technical and professional components)
7557	Bone survey, long bones for metastasis
7558	Ultrasound, M-mode (professional component only)
7559	Metastatic series, including chest
7560	Arthrography
7561	Bone survey for lead poisoning
7563	Fistula or sinus tract study
7565	Mammography, unilateral
7566	bilateral
7567	Body section radiography, laminography (in addition to scheduled X-ray fee for part)
7570	Cineradiography (add to conventional study)

7577 Examination in home with portable X-ray equipment

RADIOTHERAPY--RADIOISOTOPES

Teleradiotherapy

7600 Teleradiotherapy, X-ray 1000 KVP and higher, cobalt (I.C.)

7601 linear accelerator, balatron, etc. (I.C.)

7602 Roentgenotherapy, deep, initial

7603 subsequent

7604 maximum

7605 superficial, initial

7606 subsequent

7607 maximum

NUCLEAR MEDICINE

Radioisotope--Therapeutic

7700 Thyroid cancer (I.C.)

7704 Thyroid ablation (I.C.)

7705 Thyroid suppression-euthyroid cardiac and pulmonary conditions (I.C.)

7706 Polycythemia vera (I.C.)

7707 Hematologic and lymphoid malignant diseases (I.C.)

7708 Metastatic cancer to bone (I.C.)

7712 Intracavitary or interstitial radioisotope therapy (I.C.)

7716 Hyperthyroidism (I.C.)

7717 Radioactive iodine, initial

7718 subsequent

7719 maximum

7723	Radioactive phosphorus, initial
7724	subsequent
7725	maximum
7727	Radioactive gold, initial (I.C.)
7728	subsequent (I.C.)
7729	maximum (I.C.)
7749	Cost of providing therapeutic radioisotope (I.C.)

RADIOISOTOPES--DIAGNOSTIC

Thyroid Studies

7800	I-131 uptake, single determination
7801	multiple determination (I.C.)
7802	with scan
7804	with thyroid suppression, and/or T.S.H. stimulation (I.C.)
7805	with conversion ratio (I.C.)

Liver Studies

7820	Rose bengal study (I.C.)
7821	Rose bengal study with scan (I.C.)

Renal Studies

7825	I-131 renogram

Gastrointestinal Studies

7830	I-131 triolein or oleic acid (radioiodinated) study
7834	CO-60 (radiocobalt) B-12 Schilling test
7837	I-131 protein loss study (I.C.)
7838	Oral iron absorption study (I.C.)

Cardiovascular Studies

7840	Cardiac output (ISHA) (I.C.)
7842	Circulation time (ISHA) (I.C.)
7850	Plasma iron turnover (I.C.)
7851	Plasma iron clearance (I.C.)
7852	Fe-59 red cell utilization (I.C.)
7853	Red cell survival
7860	Plasma volume single or repeat study
7862	CR-51 red cell volume
7863	CR-51 radiated blood loss study (intestinal) (I.C.)
7865	Blood flow reactive gas
7866	Red cell sequestration (I.C.)
7867	Spleen sequestration (I.C.)

Scanning, Imaging, and Location
(Refer to Organ Studies)

7871	Bone scan, total body
7872	Bone scan, limited area scan
7873	Brain scan (nonsurgical)
7876	Brain scan with flow study
7880	Liver scan
7881	Lung scan
7882	Lung scan, ventilation scan
7889	Parathyroid scan
7891	Renal scan
7893	Spleen scan

7895	Thyroid scan
7896	Flow study (if performed separately from a scan)
7874	Flow study (if performed with static scan)
7897	Computerized axial tomography, head (professional component only)
7883	Computerized axial tomography, body scan (professional component only)
7884	Contrast medium used in addition to CAT scan
7885	Myocardial scanning
7886	Total body nuclear scan, one or more than one, for localization of tumor abscess
7887	Cerebrospinal fluid dynamic study (e.g., cisternography) (if applicable, plus lumbar puncture, Service Code 5155)
7888	Michel's diverticula scan (bowel scan)
7999	Not otherwise classified (I.C.)

433.603: Surgery Service Codes and Descriptions

Service Code	Anes. Units	Service Description
		INTEGUMENTARY SYSTEM
		Skin, Mucous Membrane, Subcutaneous and Areolar Tissues
		Incision
0001	-	First aid, no suturing required
0003	-	Drainage of small subcutaneous abscess (not specified elsewhere)
0004	4	Drainage of carbuncle or large subcutaneous abscess
0006	3	Drainage of furuncle, steratoma, or sebaceous cyst
0015	4	Drainage of pilonidal cyst or abscess
0017	3	Drainage of onychia or paronychia with or without complete or partial evulsion of nail
0020	3	Incision and removal of foreign body, subcutaneous tissue, simple
0021	-	complicated (R.F.)
0022	3	Incision and drainage of hematoma, simple
0023	-	complicated (R.F.)
0025	-	Puncture aspiration of abscess or hematoma
0032	-	Incision and exploration of subcutaneous tissue (R.F.)
		Excision and debridement
0044	-	Debridement and dressing for vascular ulcers, inpatient following minor surgery (R.F.)
0050	-	Surgical care of diabetic or vascular gangrene, inpatient only (R.F.)

		Excision and simple closure
0060	-	Biopsy of skin or subcutaneous tissue (I.P.)
0065	4	Excision of sinus of skin and subcutaneous tissues (R.F.)
		Benign lesions
0070	3	Local excision of small benign neoplastic, cicatricial, inflammatory, or congenital lesion, one with suture closure
0073	3	Scissor or sharp excision of lesion without suturing
0080	3	Wide excision of lesion, without graft or plastic closure (R.F.)
0081	3	with graft or plastic closure (R.F.)
0083	3	Excision of lesions of unusual size or number (R.F.)
0085	3	Lipectomy (R.F.)
0093	4	Excision of hidradenitis suppurative (R.F.)
0108	3	Excision of postphlebitic varicose ulcer with graft or plastic closure (R.F.)
		Malignant lesions
0114	3	Resection of malignant lesion, small, other than face (R.F.)
0118	3	scalp, face, or neck (R.F.)
0124	3	other than above (R.F.)
		Other excisions
0140	3	Excision of nail, nail bed, or nail fold, partial
0141	3	complete
0145	4	Excision of pilonidal cyst or sinus

		Introduction, miscellaneous lesions
0173	-	Injection, triamcinolone for keloids and hypertrophic scars
0175	-	Implantation of pellets, subcutaneous (R.F.)
		Repair, simple: suture of wounds or injury
0180	3	Primary, simple
0189	3	complicated (R.F.)
0192	3	Secondary (R.F.)
0195	-	Removal of sutures (R.F.)
		Repair complex
0201	3	Plastic operation on skin (for correction of contractures, etc.) without grafting (P.A.) (R.F.)
0210	3	Dermabrasion for scars due to trauma, subsequent to effective date of membership, per session (two sessions maximum), initial (P.A.)
0211	3	secondary (P.A.)
		Exclusion and/or repair, rearrangement of tissue
0231	3	Z-plasty (rearrangement and suturing of adjacent tissues) (R.F.)
0262	4	Plastic restoration of eyebrow (by graft) (P.A.) (R.F.)
		Free-skin grafts
0271	3	Plastic operation on skin with graft (list area of skin transferred, location of defect, type of graft, and age of recipient) (R.F.)
		Pedicle flaps
0314	3	Direct flap or tube pedicle transplantation (initial or subsequent), primary (R.F.)
0324	3	delay (R.F.)

0330	3	transfer (R.F.)
0332	3	final transfer (R.F.)
		Burns
0400	3	Burns, single treatment where no further treatment necessary (R.F.)
0401	3	other than Service Code 0400 (list percentage of body surface involved and depth of burn) (R.F.)
0402	3	Dressing or debridement, initial or subsequent (R.F.)
0405	3	Total care with grafts (I.C.)
		Destruction
0410	-	Cauterization or fulguration of local lesion, electro surgical destruction of local lesion, single
0411	-	up to five
0412	-	more than five (R.F.)
0413	-	Local application of radium or sclerosing substance, with or without biopsy, initial
0414	-	subsequent
0425	3	Application of radium to tongue, neck, etc. (R.F.)
0435	3	Cryotumorectomy (CO_2, liquid nitrogen, etc.)
0439	-	Not otherwise classified (I.C.)
		Breast
		Incision
0450	-	Puncture aspiration of cyst
0451	3	Mastotomy with exploration, drainage of abscess, or foreign body removal

Excision

0461	3	Biopsy of breast, incisional
0463	3	Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion, or nipple (including any other partial mastectomy), unilateral
0464	3	bilateral
0472	3	Complete mastectomy with free graft, unilateral
0473	3	Complete (simple) mastectomy, unilateral
0474	3	bilateral
0475	4	Subcutaneous mastectomy, unilateral
0476	4	bilateral
0483	4	Radical mastectomy, including pectoral muscles and axillary lymph nodes, unilateral
0486	4	Modified radical mastectomy, including breast and axillary dissection without removal of pectoral muscles
0488	4	Radical mastectomy, including pectoral muscles and axillary lymph nodes, with free graft, unilateral
0491	4	Mastoplasty: plastic operation on breast, reduction only, unilateral (P.A.) (R.F.)
0492	5	bilateral (P.A.) (R.F.)
0499	-	Not otherwise classified (I.C.)

MUSCULOSKELETAL SYSTEM

Bones

Incision

0500	4	Incision of soft tissue abscess for osteomyelitis (R.F.)
0501	4	deep, complicated (R.F.)

0505	4	Incision of periosteum and drilling of windowing of cortex for osteomyelitis, bone abscess (R.F.)
		Excision, including bone lesions
0520	3	Aspiration biopsy of bone marrow, including sternal puncture (I.P.)
0521	4	Craig needle biopsy of vertebrae (R.F.)
0522	3	Biopsy of bone, superficial, including sternal marrow excision
0523	3	deep
0525	3	Injection for intraosseous trochanteric venogram (R.F.)
		Bone lesions
0528	4	Excision of bone cyst, chondroma or exostosis, large bones (R.F.)
0529	3	small bones (R.F.)
0535	6	humerus (R.F.)
0536	6	humerus, with graft (R.F.)
0543	4	radius or ulna (R.F.)
0544	4	radius or ulna, with graft (R.F.)
0546	4	carpals or metacarpals (R.F.)
0547	4	carpals or metacarpals, with graft (R.F.)
0553	4	phalanges (fingers) (R.F.)
0554	4	phalanges (fingers), with graft (R.F.)
0555	6	pelvis (hip) (R.F.)
0560	6	femur (R.F.)
0561	6	femur, with graft (R.F.)
0563	6	tibia or fibula (R.F.)

0564	6	tibia or fibula, with graft (R.F.)
0570	4	tarsal or metatarsal (R.F.)
0571	4	tarsal or metatarsal, with graft (R.F.)
0573	4	phalanges (toes) (R.F.)
0574	4	phalanges (toes), with graft (R.F.)
0579	I.C.	Tumor of bone, other, with or without graft (I.C.)
0583	3	Excision of calcaneal spur, unilateral
0584	3	Drilling of bone for Osgood-Schlatters disease (R.F.)
0585	4	Sequestrectomy for osteomyelitis or bone abscess, minor bone (R.F.)
0586	4	major bone (R.F.)
0588	3	Excision of calcaneal spur, bilateral
		Ostectomy
0590	4	Costotransversectomy (R.F.)
0591	4	Claviculectomy, total (see Service Code 0624 for partial)
0592	4	Acromionectomy (R.F.)
0593	-	Rib resection for other than empyema (for sternal marrow excision, see Service Code 0522) (R.F.)
0594	3	Excision of head of radius
0595	3	Carpectomy, one bone
0596	3	all bones or proximal row (R.F.)
0602	4	Coccygectomy
0604	3	Patellectomy or hemipatellectomy
0606	3	Astragalectomy

0607	3	Tarsectomy
0608	3	Metatarsectomy
0610	3	Phalangectomy (R.F.)
0617	3	Excision of accessory scaphoid, other bone (I.C.)
		Partial ostectomy
0621	5	Condylectomy, mandible (R.F.)
0624	4	Claviculectomy, partial (see Service Code 0591 for total)
0628	5	Excision of myositis ossificans (R.F.)
0642	3	Bunion operation, simple, unilateral
0643	3	simple, bilateral
0644	3	radical, unilateral (Keller, McBride)
0645	3	radical, bilateral
		Partial ostectomy; partial excision of bone; craterization, guttering, or saucerization of bone; diaphysectomy
0656	4	Humerus, head or neck of radius, or olecranon process (R.F.)
0658	4	Radius or ulna (excluding radial head, neck, or olecranon process) (R.F.)
0663	3	Lesser bones, upper extremities (R.F.)
0667	4	Femur proximal tibia and/or fibula (R.F.)
0668	4	Tibia and/or fibula (R.F.)
0673	3	Lesser bones, lower extremities (R.F.)
0677	3	Lesser bones, other than extremities (R.F.)
0678	3	Excision of osteochondritis dissecans (R.F.)

		Excision of bone tumor (see Service Codes 0528 through 0579)
		Introduction
0702	3	Insertion of wire (Kirschner wire) or pin (Steinmann's pin)
0703	3	Insertion of caliper or tongs
0704	3	Insertion of thread or beaded wire
0706	3	Removal of buried wire, pin, screw, metal band, rod, nail, or plate, superficial (R.F.)
0707	3	deep (R.F.)
0715	-	Blind nailing of hip (rod) (R.F.)
		Repair, revision, and reconstruction
0722	3	Patellapexy
0723	6	Scapulopexy
0724	4	Pectus excavatum, infant
0725	11	other than infant
		Grafts
0762	3	Bone graft, radius or ulna
0763	4	humerus
0766	4	tibia
0767	4	Bone graft to femur
0769	7	other bones (I.C.)
0770	7	face or skull, autogenous (I.C.)
		Cartilage graft
0780	7	Cartilage graft, autogenous to face or skull (R.F.)
0785	-	Bone or cartilage graft, nonautogenous or heterologous graft to face or skull (R.F.)

0789	-	osteoperiosteal graft (I.C.)
0790	3	Epiphyseal stimulation (R.F.)
0803	3	Epiphyseal: diaphyseal fusion, epiphyseal arrest, epiphysiodesis, stapling, femur
0804	3	tibia and fibula
0805	3	combined (femur, tibia, and fibula)
0810	3	combined (upper and lower tibia and fibula)
0815	3	Fracture or refracture of bone, osteoclasis, with or without fixation (I.C.)
0817	3	Freeing of bone adhesions, callus or synostosis (I.C.)
		Osteotomy
0822	4	Mandible, bilateral for malocclusion (P.A.)
0823	4	Clavicle
0826	4	Humerus
0830	3	Radius (malunited Colles' fracture)
0832	3	Ulna
0848	4	Femur, subtrochanteric
0851	4	supracondylar
0853	3	Correction of bowlegs or knock-knees, unilateral
0854	3	bilateral
0855	3	Tibia
0859	3	Lesser bones (R.F.)
0868	3	Osteotomy, other (R.F.)
		Osteoplasty
0870	4	Osteotomy, mandible, bilateral sliding for malocclusion (Obswegeser technique) (P.A.)

0871	4	Osteoplasty, humerus, shortening or lengthening
0872	4	radius or ulna, shortening or lengthening
0874	4	femur, shortening or lengthening
0877	3	shortening of tibia (R.F.)
0878	4	shortening of other bones (I.C.)
0885	4	lengthening of other bones (I.C.)
0889	-	Not otherwise classified (I.C.)
		Fractures
0890	-	Skull, nonoperative (for operative, see Service Codes 5100 through 5102) (R.F.)
0895	-	Nasal, no reduction
0896	-	simple, closed reduction without splints
0898	4	with splints or traction
0900	4	simple or compound, open reduction
0902	4	Open reduction, nose with concomitant reduction of septum (R.F.)
0905	-	Malar, no reduction
0907	4	simple or compound, depressed, open reduction
0911	5	Zygoma, closed reduction (R.F.)
0912	5	open reduction (R.F.)
0916	5	with exploratory orbital floor (R.F.)
0913	5	Mid-facial, including orbital wall or floor, closed reduction (R.F.)
0914	5	open reduction, unilateral (R.F.)
0915	5	bilateral (R.F.)
0917	5	Orbital fractures, with alloplastic implant (R.F.)

0918	5	with bone graft (R.F.)
0920	-	Maxilla, simple, no reduction
0921	5	with displacement, closed reduction
0923	5	simple or compound, open reduction
0930	-	Mandible, no reduction
0931	5	closed reduction
0932	5	open reduction (R.F.)
		Spine and trunk
0940	-	Ribs, simple, strapping
0941	3	compound (R.F.)
0942	3	multiple (R.F.)
0945	-	Sternum, no reduction
0946	3	simple or compound, depressed, open reduction (R.F.)
0949	4	Vertebral process, one or more, no reduction (R.F.)
0950	4	one or more, open reduction (R.F.)
0951	4	Vertebral body, one or more, no reduction (R.F.)
0952	4	one or more, closed reduction (I.C.)
0953	4	one or more, open reduction (R.F.)
0973	-	Sacrum, simple, closed reduction (I.C.)
0974	-	simple or compound, with operation (R.F.)
0980	-	Coccyx, simple, closed reduction (I.C.)
0981	4	open reduction (R.F.)
0983	-	Clavicle, no reduction
0984	3	closed reduction

0985	3	simple or compound, open reduction
0986	-	Scapula, no reduction
0987	3	closed reduction
0988	3	simple or compound, open reduction
0990	3	Scapula plus acromial process, simple, closed reduction (R.F.)
0991	3	compound, closed reduction (R.F.)
0992	3	simple or compound, open reduction (R.F.)
0993	-	Humerus, surgical neck, simple, not requiring manipulation
0994	3	loose, with or without dislocation at the shoulder, requiring manipulation without skeletal traction
0995	4	skeletal pinning with external fixation
0996	4	simple or compound, open reduction
0998	4	Humerus, shaft, skeletal pinning with external fixation
1000	-	Humerus, shaft, simple, without displacement
1001	3	with displacement, closed reduction
1002	4	shaft, simple or compound, open reduction (R.F.)
1003	4	shaft, compound (R.F.)
1005	3	supracondylar, no reduction (R.F.)
1006	-	closed reduction (R.F.)
1007	-	open reduction (R.F.)
1010	-	Elbow, one or more bones, no reduction
1011	3	simple, closed reduction
1012	4	simple or compound, open reduction with or without internal or external skeletal fixation

1013	3	compound (I.C.)
1020	-	Radius, head or neck, no reduction
1021	3	closed reduction
1022	-	simple or compound, open reduction
1023	4	Radius, head, compound (I.C.)
1030	-	Radius, shaft, no reduction
1031	3	closed reduction
1032	4	open reduction
1034	-	Ulna, shaft, no reduction
1035	3	simple, closed reduction
1036	4	simple or compound, open reduction
1037	4	compound (I.C.)
1038	4	skeletal pinning with external fixation (R.F.)
1039	3	Radius and ulna, greenstick
1040	-	simple, without displacement
1041	3	partial displacement, both bones
1042	4	simple or compound, open reduction
1043	4	complete displacement, both bones, closed
1044	-	Colles', no reduction
1045	3	(including ulnar styloid), simple, closed reduction
1046	4	simple or compound, open reduction
1047	4	compound, closed reduction (R.F.)
1048	4	skeletal pinning with external fixation (R.F.)
1049	-	Open treatment of fracture of upper extremity with homograft (I.C.)

1050	-	Carpal, one or more, no reduction
1051	3	closed reduction
1052	4	open reduction
1055	3	Navicular, simple, closed reduction (R.F.)
1056	4	simple or compound, with operation (R.F.)
1057	4	compound, closed reduction (R.F.)
1065	-	Metacarpal, no reduction
1066	3	closed reduction
1067	4	open reduction
1069	4	skeletal pinning with external fixation
1070	-	multiple, closed reduction (R.F.)
1071	-	multiple, open reduction (R.F.)
1082	3	Phalanges, closed with external fixation (R.F.)
1083	-	Phalanx, phalanges, any joint, no reduction
1084	3	closed reduction
1085	4	open reduction (R.F.)
1086	-	more than one, no reduction (R.F.)
1087	-	more than one, closed reduction (R.F.)
1088	-	more than one, open reduction (R.F.)
		Pelvis
1090	-	Pelvis, one or more bones, no reduction (R.F.)
1091	3	closed reduction (I.C.)
1092	3	compound (I.C.)
1093	3	simple or compound, open reduction (R.F.)
1095	-	Acctabulum, simple, closed reduction, no displacement (R.F.)

1096	4	central, with displacement (R.F.)
1097	4	compound (R.F.)
1098	4	simple or compound, open reduction (R.F.)
		Lower extremity
1100	-	Femur, neck, no reduction (R.F.)
1101	3	simple, closed reduction
1102	6	simple or compound, open reduction with replacement prosthesis
1103	-	intertrochanteric, no reduction (R.F.)
1104	3	closed reduction
1105	6	open reduction
1109	6	neck, open reduction with or without internal or external skeletal fixation
1110	3	shaft, including supracondylar, no reduction (R.F.)
1111	3	simple, closed reduction
1112	5	simple or compound, open reduction with or without internal or external skeletal fixation
1113	4	compound (R.F.)
1117	3	slipped epiphysis, closed reduction
1118	6	open reduction
1119	6	chronic, open reduction (R.F.)
1120	-	Patella, simple, closed reduction
1121	4	simple or compound, open reduction
1122	4	compound (R.F.)
1123	-	Knee, one or more bones, no reduction
1124	3	intra-articular, closed reduction

1130	-	Tibia, shaft, no reduction
1131	3	shaft, simple, closed reduction
1132	4	shaft, simple or compound, open reduction
1133	4	shaft, compound (R.F.)
1134	-	malleolus, no reduction
1135	3	malleolus, simple, closed reduction
1136	4	malleolus, simple or compound, open reduction
1137	4	malleolus, compound (R.F.)
1139	-	Fibula, shaft, no reduction
1140	3	shaft, simple, closed reduction
1141	4	shaft, simple or compound, open reduction
1142	-	malleolus, no reduction
1143	3	malleolus, simple, closed reduction
1144	4	malleolus, simple or compound, open reduction
1145	-	Tibia and fibula, shafts, no reduction
1146	3	shafts, simple, closed reduction
1147	4	shafts, simple or compound, open reduction
1148	4	shafts, compound (R.F.)
1149	3	closed with external fixation (R.F.)
1150	-	Ankle, bimalleolar, no reduction
1151	3	bimalleolar (including Potts), simple, closed reduction
1152	4	compound (R.F.)
1153	4	simple or compound, open reduction
1154	-	trimalleolar, no reduction

1155	3	simple, closed reduction
1156	4	simple or compound, open reduction
1157	4	compound (R.F.)
1160	-	Os calcis, no reduction
1161	4	simple, closed reduction
1162	4	simple or compound, open reduction with or without internal or external skeletal fixation
1164	4	compound (R.F.)
1165	-	Astragalus, no reduction
1166	3	simple, closed reduction
1167	4	simple or compound, open reduction
1168	4	compound (R.F.)
1170	-	Tarsal, one or more, no reduction
1171	3	closed reduction
1172	4	open reduction
1173	4	compound (R.F.)
1175	-	Metatarsal, one or more, no reduction
1176	3	closed reduction
1177	4	open reduction
1178	4	compound (R.F.)
1180	-	Fracture, great toe, without reduction
1181	3	closed reduction
1182	4	open reduction, with or without internal or external skeletal fixation (R.F.)
1183	3	multiple, closed reduction
1184	4	multiple, open reduction (R.F.)

1185	-	Other than great, without reduction
1186	3	closed reduction
1187	4	open reduction, with or without internal or external fixation (R.F.)
1188	3	Toes, phalanges, multiple, closed reduction (R.F.)
1189	4	multiple, open reduction (R.F.)
1190	3	closed with external fixation (R.F.)
1198	-	Open treatment of fracture of lower extremity with homograft (I.C.)
1199	-	Not otherwise classified (I.C.)
		Joints
		Arthrotomy with exploration, drainage, or removal of loose or foreign body
1200	4	Shoulder
1201	3	Elbow
1203	3	Wrist
1204	3	Metacarpal phalangeal joint (R.F.)
1205	3	Interphalangeal joint (fingers) (R.F.)
1206	5	Hip
1207	3	Knee
1208	3	Ankle
1210	3	Other joints of lower extremity (I.C.)
		Capsulotomy: cutting or division of joint capsule
1220	4	Shoulder (I.P.)
1221	3	Elbow (I.P.)

1222	3	Knee (I.P.)
1226	3	Ankle (I.P.)
1228	3	Other joints of upper extremity (I.P.) (I.C.)
1229	5	Hip (I.P.)
1233	3	Wrist (I.P.)
1237	3	Other joints of lower extremity (I.P.) (I.C.)
		Arthrocentesis and introduction
1240	3	Arthrocentesis for septic joint
1241	-	Injection of TM joint for hypermobility (R.F.)
1243	3	Arthrography, injection of media
1245	-	Nonspecific injection, anesthetic or steroids, following injury (old and new)
1246	3	Arthrocentesis with joint lavage
1247	3	Diagnostic arthrocentesis with biopsy
1248	3	Arthroscopy (R.F.)
		Arthrectomy
1250	5	Excision of temporomandibular joint
1251	-	Injection of joints for arthritis
		Meniscectomy
1260	5	Meniscectomy, temporomandibular joint (R.F.)
1261	3	excision of semilunar cartilage of knee joint (S.O.)
		Synovectomy
1270	4	Synovectomy, shoulder, complete (R.F.)
1271	3	elbow
1274	3	other joints of upper extremity (I.C.)

1279	5	hip
1280	3	knee (I.P.)
1281	3	ankle (I.P.)
1297	3	other joints of lower extremity (I.C.)
1298	3	Punch biopsy of synovial membrane (I.P.)
		Arthroplasty
1310	5	Arthroplasty, temporomandibular joint (R.F.)
1311	4	shoulder
1312	3	elbow
1313	3	wrist
1317	3	finger or thumb (R.F.)
1320	3	finger, more than one (R.F.)
1324	3	other joints of upper extremity (I.C.)
1327	6	hip, cup, or prosthesis
1328	6	Acetabuloplasty, cup or prosthesis with transplant of greater trochanter (R.F.)
1330	6	total hip, acetabular and proximal femoral prosthetic replacement with or without cement
1331	6	secondary hip arthroplasty, with or without prosthesis (R.F.)
1335	3	knee
1337	3	ankle
1339	3	toe, one or more joints (R.F.)
1341	3	other joints of lower extremity (R.F.)
1345	6	Modified arthroplasty following removal of prosthesis (I.C.)
1348	4	Acromionectomy, total with drill holes and tendon transfer (R.F.)

1402	3	more than one
		Bunion operation (see Service Codes 0642 through 0645)
1408	3	Hallux rigidus, repair of one
1409	-	Triple arthrodesis, unilateral with tendon transplant
1410	3	Foot, triple arthrodesis, unilateral
1411	3	bilateral (R.F.)
1412	3	Other joints of lower extremity (I.C.)
1413	3	Tarsal joints, one or more
		Repair (joints)
1420	4	Capsulorrhaphy: suture or repair of joint capsule for recurrent dislocation, shoulder, Nicola
1421	4	Bankhart
1424	3	patella
1425	3	Capsulorrhaphy: other joints (see also Service Code 1438) (I.C.)
1426	3	Suture of torn, ruptured, or severed collateral ligaments, knee (R.F.)
1427	3	Suture of torn, ruptured, or severed cruciate, knee (R.F.)
1428	3	Suture of torn, ruptured, or severed collateral and cruciate, knee (R.F.)
1429	3	Reconstruction, both collateral or cruciate ligaments, knee (R.F.)
1432	3	Reconstruction, both collateral ligaments, ankle (R.F.)
1433	3	Reconstruction, metacarpophalangeal joint (R.F.)
1434	3	Reconstruction, interphalangeal joint (R.F.)

1436	3	Division on carpal ligament for carpal tunnel syndrome
1437	3	Repair or reconstruction of ligaments, other (I.C.)
1438	3	Capsulorrhaphy: multiple hand or fingers (see also Service Code 1425) (I.C.)
		Manipulation under general anesthesia
1441	4	Spine (I.P.)
1443	3	Shoulder (I.P.)
1444	3	Elbow (I.P.)
1445	3	Wrist (I.P.)
1446	3	Digits, one or more (I.P.) (R.F.)
1450	3	Hip (I.P.)
1451	3	Knee (I.P.)
1452	3	Ankle (I.P.)
		Dislocations
1460	3	Temporomandibular
1461	5	open (R.F.)
1464	5	Vertebra, any level, closed reduction (I.C.)
		Arthrodesis, spinal
1354	7	Duyer interior spinal fusion (thoracotomy exposure) (S.O.)
1361	7	Fusion, cervical, with iliac or autogenous graft (S.O.) (R.F.)
1364	7	Lumbosacral fusion (S.O.)
1373	7	Spinal fusion of more than two segments (S.O.)
1375	7	Multiple segment fusion of spine with insertion of Harrington rod (R.F.)

		Arthrodesis, other joints
1380	4	Shoulder
1381	3	Elbow
1382	3	Wrist
1385	3	Carpometacarpal joint, with or without external fixation (R.F.)
1387	3	Metacarpophalangeal joint, with or without external fixation (R.F.)
1390	3	Finger or thumb (R.F.)
1392	3	Finger, more than one (R.F.)
1395	6	Hip
1397	3	Knee
1399	-	Stabilization of joint by bone block
1400	3	ankle
1401	3	hammer toe, one
1465	8	open reduction (R.F.)
1466	8	Vertebral fracture, open reduction, with bone graft (R.F.)
1477	3	Clavicle, sternoclavicular, closed reduction
1478	4	open reduction
1481	3	Acromioclavicular, closed reduction
1482	4	open reduction
1485	3	Shoulder (humerus), closed reduction
1486	4	open reduction
1489	-	Subluxation of head of radius, without cast
1492	-	with cast

1494	3	Elbow, closed reduction
1495	4	open reduction
1497	3	Wrist, carpal, one bone, closed reduction
1498	4	open reduction
1500	3	Thumb, closed reduction
1502	4	open reduction (R.F.)
1504	3	Wrist, more than one bone, closed reduction
1505	4	open reduction
1506	3	Metacarpal, one bone, closed reduction
1507	-	compound (R.F.)
1508	4	open reduction
1509	3	Metacarpal, multiple, closed or open (R.F.)
1511	3	Finger, one, one or more joints, closed reduction
1512	4	open reduction (R.F.)
1515	4	Hip (femur), closed reduction
1517	6	open reduction
1518	-	Hip, congenital dislocation, unilateral, closed reduction
1519	-	bilateral, closed reduction
1520	-	unilateral or bilateral, open reduction (R.F.)
1521	3	Knee (tibia), simple, closed reduction
1523	4	simple or compound, open reduction
1524	4	compound, closed reduction (R.F.)
1525	-	Patella, closed reduction without cast
1526	-	simple, closed reduction, with cast

1527	4	simple or compound, open reduction
1529	-	Hauser operation for dislocated patella
1533	3	Ankle, simple, closed reduction
1534	4	simple or compound, open reduction
1536	3	Tarsal, one bone, simple, closed reduction
1538	4	simple or compound, open reduction
1539	4	compound, closed reduction (R.F.)
1540	3	Astragalo-tarsal, simple, closed reduction
1541	4	compound, closed reduction (R.F.)
1542	4	simple or compound, open reduction
1546	3	Metatarsal, one bone, simple, closed reduction
1548	4	simple or compound, open reduction
1549	4	compound, closed reduction (R.F.)
1550	3	Metatarsal, more than one, closed (R.F.)
1551	4	open (R.F.)
1552	3	Toe, one, simple, closed reduction
1554	4	simple or compound, open reduction (R.F.)
1555	4	compound, closed reduction (R.F.)
1556	3	Toe, more than one, closed reduction
1558	4	open reduction (R.F.)
1559	4	compound (R.F.)
1569	-	Not otherwise classified (I.C.)

Bursae

Incision

1570	3	Drainage of infected bursa (R.F.)
1571	4	Excision of subdeltoid calcareous deposits
1572	3	Excision of subtrochanteric calcareous deposits

Introduction

1573	-	Aspiration of bursa with injection of medication by single or multiple needling technique (maximum of six per 12 months) (I.P.)
1574	-	Removal of calcium in the case of calcified tendonitis by irrigation through single or multiple needles (maximum of three per 12 months)

Excision

1580	4	Subacromial bursa
1581	3	Olecranon bursa
1582	3	Radical excision of bursae, forearm viz., tenosynovitis fungosa, tbc., and other granulomas (R.F.)
1583	3	Subdeltoid bursa (R.F.)
1585	3	Ischial bursa
1587	3	Prepatellar bursa
1588	3	Excision, bursa of heel (R.F.)
1589	-	Not otherwise classified (I.C.)

Muscles

Incision

1594	3	Drainage of abscess or infection of muscle (R.F.)
1595	3	Drainage of hematoma of muscle (R.F.)

		Excision
1600	3	Biopsy of muscle
1602	3	Local excision of lesion of muscle (R.F.)
1605	5	Cutting, division, or transection of other muscle (I.C.)
		Repair
1610	5	Division of scalenus anticus, without resection of cervical rib
1611	5	with resection of cervical rib
1612	5	Division of sternomastoid for torticollis, open operation
1618	3	Opponens, transfer (R.F.)
1624	4	Transplant of muscle (R.F.)
1628	3	Pedicle graft of muscle (R.F.)
		Suture
1630	3	Suture of ruptured quadriceps (R.F.)
1631	4	Suture of ruptured biceps (R.F.)
1632	9	Suture of ruptured diaphragm (I.P.)
1635	3	Suture of muscle wound or injury (R.F.)
		Removal
1640	3	Removal of foreign body in muscle, simple (R.F.)
1641	3	deep or complicated (R.F.)
1649	-	Not otherwise classified (I.C.)

Tendons, Tendon Sheaths, and Fascia

Incision

Fasciotomy

1653	3	Fasciotomy, aponeurotomy: cutting of fascia subcutaneous (R.F.)
1655	3	Stripping of ilium (Soutter operation)
1656	3	Fasciotomy, Ober-Yount (R.F.)
1658	3	Division of iliotibial band
1662	3	Plantar fasciotomy, single palm or sole, subcutaneous, blind
1664	3	Incision of tendon sheath for stenosing tenosynovitis, including freeing of tendons or removal of foreign body

Tenotomy

1665	3	Tenotomy, single digit, subcutaneous
1666	3	multiple digits (R.F.)
1667	3	hip abductors, subcutaneous
1668	3	open operation
1675	3	Medial release with capsulotomies M/T joints and/or arthrodesis (R.F.)
1676	3	Medial release, unilateral (R.F.)
1677	3	bilateral (R.F.)
1678	3	with long toe extensor transplant, unilateral (R.F.)

Excision

1680	3	Excision of lesion of tendon or fibrous sheath, including ganglion, digits only
1681	3	in other locations
1689	3	Removal of foreign body or rice bodies in tendon sheath (R.F.)

1690	4	Excision of Baker's cyst (synovial cyst of popliteal space)
		Fasciectomy
1694	3	Fasciectomy for Dupuytren's contracture, complete, including finger
1695	3	extensions and vertical bands, radical
1698	3	other than Dupuytren's (R.F.)
		Tenosynovectomy
1704	4	Tenosynovectomy, one tendon sheath (R.F.)
1708	4	more than one (R.F.)
		Repair
1725	2	Free fascial graft to face (R.F.)
1726	4	Ruptured supraspinatus tendon or musculotendinous cuff shoulder
1727	4	Complete shoulder cuff avulsion
1728	3	Avulsed tendon to skeletal attachment, one tendon (R.F.)
1729	3	more than one tendon (R.F.)
1731	3	Free fascial graft for reconstruction of tendon pulley or repair of bowstring tendon (I.P.) (R.F.)
1733	3	For reconstruction of tendon pulley or repair of bowstring tendon to form gliding surface for tendons (R.F.)
1734	4	Sling procedure for splay foot, unilateral
1735	3	Abdominal fascial transplants, bilateral (I.C.)
1738	4	Sling procedure for splay foot, bilateral
		Tenotomy
1755	3	Tenotomy, corrective major (R.F.)
1757	4	Adductor tenotomy with obturator neurectomy, unilateral (R.F.)

1758	4	bilateral (R.F.)
		Tenoplasty
1761	3	Flexor plasty of elbow (R.F.)
1764	3	Patellar advancement
1766	3	Lengthening or shortening tendon (R.F.)
1767	3	Free tendon graft (R.F.)
		Tenolysis
1770	3	Tenolysis, single (R.F.)
1771	3	multiple (R.F.)
		Repair
		Primary flexors
1789	3	Repair of flexor tendon, one or more (R.F.)
		Secondary
1796	3	Transfer, or transplant, or free graft of tendon, single, distal to elbow, distal to knee (R.F.)
1797	3	Single, elbow to shoulder, knee to hip (R.F.)
1798	3	Transfer, transplant, or graft multiple tendons (R.F.)
		Primary extensor
1800	3	Extensor tendon, one hand, distal to wrist
1803	3	one foot, distal to ankle
		Secondary
1804	3	Hand dorsum, with or without free graft (includes obtaining graft) (R.F.)
1805	3	Finger dorsum, with or without free graft (includes obtaining graft) (R.F.)
1806	3	Leg or ankle, with or without graft (includes obtaining graft) (R.F.)

1807	3	Foot with free graft (includes obtaining graft) (R.F.)
1808	3	Extensor tendon repair, more than one (hand or foot) (R.F.)
1809	3	one, forearm or leg
1818	3	more than one (R.F.)

Tenodesis

1820	3	Ruptured quadriceps insertion
1821	4	Ruptured biceps tendon from insertion elbow
1825	4	Lengthening or shortening of Achilles tendon, unilateral only (R.F.)
1826	3	bilateral (R.F.)
1827	3	Ruptured Achilles tendon repair, simple (R.F.)
1828	3	complicated, with posterior capsulotomy (R.F.)
1829	-	Not otherwise classified (I.C.)

Extremities

Incision

1832	3	Drainage of felon
1833	3	Drainage of tendon sheath infection for tenosynovitis (R.F.)
1834	3	Drainage of single palm and/or wrist, ulnar or radial bursa infection (R.F.)
1837	3	Drainage of single, infected space of hand (lumbrical, hypothenar, thenar, middle palmar, etc.), with or without tendon sheath involvement
1838	3	Drainage of multiple infected spaces of hand, with or without tendon sheath involvement (R.F.)

		Repair
1840	3	Pollicization of a digit (R.F.)
1842	3	Freeing of web fingers, with flaps
1844	3	with grafts
1849	-	Not otherwise classified (I.C.)
		Amputation, upper extremities
1850	15	Interthoracoscapular
1851	5	Cineplasty, complete procedure (R.F.)
1852	3	Repair of traumatic amputation, finger, hand, or arm (R.F.)
1853	3	Hand, through metacarpal bones
1854	3	Metacarpal, with finger or thumb, one with split or Wolff graft, or skin plastic and/or tenodesis, with definitive resection of palmar digital nerve (R.F.)
1855	3	more than one (R.F.)
1857	3	Finger, any joint or phalanx, one
1858	3	more than one, with split or Wolff graft, or skin plastic and/or tenodesis, with definitive resection of volar digital nerves (R.F.)
1859	3	Revision of amputation stump, hand or fingers (R.F.)
		Amputation, lower extremities
1860	15	Interpelviabdominal
1861	5	Ankle, with skin plastic and resection of nerves (Syme, Pirogoff)
1862	5	Foot, midtarsal (Chopart)
1863	5	Foot, transmetatarsal
1864	5	Metatarsal, with toe, split or Wolff graft, or skin plastic and/or tenodesis, with definitive resection of digital nerves (R.F.)

1866	5	Toe, any joint or phalanx, one
1867	5	Toe, more than one, split or Wolff graft, or skin plastic and/or tenodesis, with definitive resection of digital nerves (R.F.)
1868	5	Metatarsal, with toe, more than one (R.F.)
1869	3	Repair of traumatic amputation of toes, foot, or leg (R.F.)
1870	4	Arm, through humerus
1871	4	Forearm, through radius and ulna
1872	5	Thigh, through femur, including supracondylar
1873	5	Leg, through tibia and fibula (R.F.)
1874	3	through condylus of femur (Gritti-Stokes) (R.F.)
1877	4	Guillotine thigh, through femur
1878	5	Guillotine leg, through tibia and fibula (R.F.)
		Revision
1887	4	Subsequent revision or reamputation through femur (R.F.)
1888	4	through tibia and fibula (R.F.)
1889	3	Revision of amputation stump, leg, foot, or toes (R.F.)
		Disarticulation
1890	9	Disarticulation of shoulder
1891	3	wrist
1892	10	hip
1893	5	knee
		Supernumerary
1897	3	Amputation of supernumerary digits, hand or foot (R.F.)

		Replantation
1898	-	Replantation of traumatic amputation (R.F.)
1899	-	Not otherwise classified (I.C.)
		Casting and Strapping: Body and Upper Extremities
		Casts
1901	4	Turnbuckle jacket, body only for scoliosis (I.P.)
1903	4	Turnbuckle spica jacket for scoliosis (I.P.)
1905	4	Body, shoulder to hips (I.P.)
1906	5	including head (Minerva) (I.P.)
1910	3	Shoulder spica (I.P.)
1911	3	Shoulder to hand (long arm) (I.P.)
1913	3	Elbow to fingers (short arm) (I.P.)
1915	3	Hand and lower forearm (I.P.)
		Splints
1922	3	Short arm (forearm and hand)
1925	-	Plaster collar, cervical (R.F.)
1926	-	including head (R.F.)
		Strapping
1930	-	Adhesive strapping of chest, other than for rib fracture (R.F.)
1931	-	Adhesive strapping of low back for acute traumatic injury (R.F.)
1933	-	Sprain, wrist or elbow, strapping
		Casting and Strapping: Lower Extremities
		Casts
1940	3	Spica, unilateral (hip to foot) (I.P.)

1942	3	bilateral (I.P.)
1944	3	Long leg cast (thigh to toes) (I.P.)
1950	3	Short leg cast (below knee to toes) (I.P.)
1952	3	Walking or ambulatory type (I.P.)
1955	3	Club foot cast with molding or manipulation, unilateral (I.P.)
1956	3	bilateral (I.P.)
		Splints
1962	3	Molded plaster splint to leg, short, under age 10
1963	3	age 10 and over
1967	-	Application of Denis Browne splint
		Strapping
1972	-	Sprains, ankle strapping
1973	-	Unna boot
1974	-	Application of "Aufranc Boot" (or Gibney)
		Removal or repair
1985	3	Wedging of cast for foot deformity
1989	-	Removal of plaster cast, extremity
1990	-	body
1999	-	Not otherwise classified (I.C.)
		RESPIRATORY SYSTEM
		Nose
		Incision
2000	4	Drainage of nasal abscess or hematoma
2003	4	Drainage of septal abscess or hematoma

2008	4	Biopsy, bone (I.P.) (R.F.)
		Excision
2010	4	Biopsy, soft tissue of nose (I.P.)
2011	4	Excision of nasal polyps, multiple, one or more stages, unilateral or bilateral (I.P.)
2013	4	Excision of nasal polyp (I.P.)
2014	4	Excision of skin of nose for rhinophyma (R.F.)
2017	4	Turbinectomy, complete or partial, unilateral or bilateral (I.P.)
2018	4	Excision of choanal lesion (R.F.)
2023	4	Lateral rhinotomy for removal of tumor (R.F.)
		Endoscopy
2030	-	Removal of foreign body in nose (I.P.)
		Repair
2042	4	Rhinoplasty, lateral and alar cartilages and/or elevation of nasal tip including major septal repair (septectomy) (S.O.) (R.F.)
2043	4	Rhinoplasty, complete, including grafts (S.O.) (R.F.)
2044	4	without grafts (S.O.) (R.F.)
2046	4	Transantral vidian neurectomy for vasomotor rhinitis (R.F.)
2047	4	Vidian neurectomy and/or excision of sphenopalatine ganglion (R.F.)
2048	4	Septectomy, submucous resection (S.O.)
2049	4	with correction of nasal deformity (S.O.)
2051	4	Repair of choanal atresia, intranasal (R.F.)
2052	4	palatal approach (R.F.)
2053	4	Removal of intranasal adhesions or scarring (R.F.)

2054	3	Closure of dental (oromaxillary) fistula with flap
2055	4	Closure of dental (oromaxillary) fistula with flap and radical antrotomy
2056	3	Closure of oronasal fistula (local mucoperiosteal pedicle flap)
		Destruction
2060	3	Infraction of turbinate, unilateral or bilateral (I.P.) (R.F.)
2063	4	Cauterization of turbinate, unilateral or bilateral (I.P.)
		Manipulation
2070	4	Control of primary nasal hemorrhage
2071	-	Anterior-posterior nasal packing (R.F.)
2072	-	Transantral ligation, internal maxillary artery (for epistaxis) (R.F.)
2078	4	Filiform passed through nose and out through mouth, strings with rubber bougies attached pulled through mouth and up through for choanal atresia
2079	-	Not otherwise classified (I.C.)
		Accessory Sinuses
		Incision
2080	4	Antrum puncture and/or wash, unilateral or bilateral, initial
2082	4	subsequent
2084	4	Maxillary sinusotomy, simple, antrum window, intranasal, unilateral
2085	4	bilateral (R.F.)
2086	4	radical (Caldwell-Luc), unilateral
2087	4	bilateral (R.F.)

2088	4	Sphenoid sinusotomy (R.F.)
2090	4	Frontal sinusotomy, external, simple (trephine operation)
2092	4	radical, obliterative, unilateral
2093	4	bilateral
2094	4	Removal of foreign body from maxillary sinus (R.F.)
2095	4	Combined external frontal, ethmoid, and sphenoid sinusotomy, unilateral
2096	4	bilateral (R.F.)
2097	4	Frontal sinusotomy, external, radical (R.F.)
		Excision
2100	4	Ethmoidectomy intranasal, unilateral or bilateral
2102	4	external, unilateral
2103	4	external, bilateral
2104	4	Anterior ethmoidectomy
2108	-	Not otherwise classified (I.C.)
		Larynx
		Excision
2109	3	Maxillectomy (R.F.)
2110	6	Laryngofissure, with removal of tumor
2111	-	External drainage of laryngeal abscess (R.F.)
2112	6	External drainage for perichondritis (R.F.)
2117	6	Supraglottic partial laryngectomy, with partial pharyngectomy
2118	6	Laryngectomy, complete, without neck dissection
2120	6	with neck dissection, radical

2121	6	Hemilaryngectomy
2125	6	Arytenoidectomy or arytenoidopexy
2126	6	Epiglottidectomy, external approach
2127	6	end-oral approach
		Introduction
2130	5	Intubation of larynx or endotracheal intubation (I.P.) (R.F.)
2132	4	Injection of radiopaque substance into larynx for bronchography or laryngography, indirect method (I.P.)
2133	-	Dacryocystography
2134	-	Bronchography, bilateral
2135	-	Orbitography
2136	-	Paranasal sinuses, contrast exam
		Endoscopy
2140	6	Laryngoscopy, direct, diagnostic (I.P.)
2143	6	with biopsy (I.P.)
2144	6	with aspiration (I.P.) (R.F.)
2146	6	operative, including removal of foreign body (I.P.)
2148	6	including removal of papilloma or other tumor (I.P.)
2151	6	Lynch suspension (R.F.)
2152	6	Laryngoscopy, with insertion of radioactive substance (R.F.)
2153	6	Suspension laryngoscopy (other than Lynch suspension)
2154	6	Suspension laryngoscopy with tumor removal (R.F.)
		Repair
2160	6	Laryngoplasty, plastic operation of larynx (R.F.)
		Dilation of larynx or trachea
2165	6	Laryngoplasty, end-oral approach (R.F.)

		Incision
2170	5	Tracheotomy (I.P.)
2171	5	for acute tracheal bronchitis (R.F.)
2172	5	Revision of tracheotomy (R.F.)
		Endoscopy
2180	6	Bronchoscopy, diagnostic (I.P.)
2181	6	with biopsy (I.P.)
2184	6	with removal of foreign body (I.P.) (R.F.)
2185	6	with excision of tumor (I.P.) (R.F.)
2186	6	with aspiration of bronchus (I.P.)
2188	6	with drainage of lung abscess or cavity, initial (I.P.) (R.F.)
2192	6	with lipiodol injection (I.P.)
2193	6	with insertion of radioactive substance (I.P.) (R.F.)
2195	6	with insertion of silastic tube into trachea (I.P.) (R.F.)
		Introduction
2200	-	Insertion of catheter for bronchospirometry (R.F.)
2201	6	Bronchospirometry and catheterization of bronchi (I.P.)
2205	-	Cisternography
2207	6	Tracheal aspiration (I.P.) (R.F.)
2208	6	second (R.F.)
2209	6	third (maximum) (R.F.)
		Repair
2210	6	Tracheoplasty, plastic operation on trachea, cervical (R.F.)

2211	13	intrathoracic
		Tracheoplasty, reconstruction (see also Service Codes 2890 through 2898)
2216	13	Bronchoplasty, with graft repair (R.F.)
2217	13	with excision of stenosis and anastomosis (R.F.)
2218	13	with lobectomy and anastomosis
		Suture
2220	6	Tracheorrhaphy: suture of external tracheal wound or injury, cervical (R.F.)
2221	13	intrathoracic (R.F.)
2224	6	Closure of tracheostomy or tracheal fistula, cervical
2225	15	Closure of tracheoesophageal fistula, intrathoracic
2227	15	congenital, with end-to-end anastomosis (R.F.)
2229	-	Not otherwise classified (I.C.)
		Lungs and Pleura
		Incision
2230	4	Thoracentesis, diagnostic puncture of pleural cavity for aspiration (I.P.)
2231	4	for aspiration of massive effusion
2233	4	Insertion of chest tubes (I.P.)
2235	-	Pleural biopsy, open operation (I.P.)
2236	13	Thoracotomy, exploratory, with or without biopsy
2239	13	with repair of lung wound, injury, or perforation (R.F.)
2240	13	with open intrapleural pneumonolysis
2241	13	with open drainage of empyema cavity by rib resection (I.P.)

2243	13	with removal of intrapleural foreign body or fibrin body
2244	13	with cardiac massage
2245	13	with drainage of pulmonary abscess or cyst
2246	13	with removal of foreign body from lung
2247	15	Total pulmonary decortication
2249	-	Cruciate incision of thickened scar deposited on visceral pleura (Ransohoff) (R.F.)
2250	13	Reopening for exploration or control of hemorrhage (R.F.)
		Excision
2262	4	Pneumonocentesis, puncture of lung for aspiration biopsy (I.P.)
2263	13	Total pneumonectomy
2264	13	Pneumonotomy, exploratory
2265	13	Total or subtotal lobectomy
2269	13	Pneumonotomy with plication and/or multiple wedge excision of blebs, with or without poudrage
2270	13	Wedge resection
2276	13	Pleurectomy, any type (I.P.)
		Endoscopy
2280	4	Thoracoscopy, exploratory (I.P.)
2281	4	with biopsy (I.P.)
2282	4	Closed intrapleural pneumonolysis
		Surgical collapse therapy
2290	10	Thoracoplasty: extrapleural resection of ribs, any type, first stage
2291	9	second stage

2292	9	third stage
2293	9	Thoracoplasty (Schede) (R.F.)
2294	10	Extrapleural pneumonolysis, including associated filling or packing procedures
2296	-	Pneumothorax, intrapleural injection of air, initial
2297	-	subsequent (R.F.)
2299	-	Not otherwise classified (I.C.)

CARDIOVASCULAR SYSTEM

Heart and Pericardium

Incision

2300	20	Cardiotomy, with exploration or removal of foreign body
2303	20	Pleuropericardial fenestration (R.F.)
2304	20	Pericardiolysis (R.F.)
2305	20	Pericardiotomy, with exploration, drainage, or removal of foreign body
2306	20	Poudrage operation for coronary
2307	6	Pericardiocentesis: puncture of pericardial space for aspiration (I.P.)
2312	20	Creation of atrial septal defect (Blalock-Hanlon) (R.F.)
2314	20	using hypothermia and inflostasis (R.F.)

Excision

2320	20	Pericardiectomy (pericardiolysis)
2321	20	Excision of auricular appendage
2322	20	Excision of intracardiac tumor, with bypass (R.F.)

Introduction

2330	20	Implantation of intrathoracic cardiac pacemaker (R.F.)

2340	10	Insertion of transvenous electrode, with axillary-pectoral battery (R.F.)
2341	5	Insertion of transvenous electrode
2342	-	Insertion of temporary transvenous pacemaker (R.F.)
2343	-	Revision of pacemaker circuit or battery (R.F.)
		Suture
2350	20	Cardiorrhaphy: suture of heart wound or injury
2353	20	Pericardiorrhaphy: suture of pericardial wound or injury (R.F.)
		Repair
2360	20	Operation for regurgitation
2362	20	Valvulotomy or commissurotomy
2363	20	Repair, mitral regurgitation, with bypass (R.F.)
2364	20	Open heart, single valve replacement, with bypass
2367	20	double valve replacement, with bypass
2368	20	triple valve replacement, with bypass
2369	20	single valve replacement, with aortic resection (R.F.)
2372	20	Repair, valvular or infundibular stenosis, valvulotomy, with bypass (isolated pulmonic) (R.F.)
2373	20	Internal mammary artery implantation into the myocardium, unilateral
2374	20	Internal mammary artery implantation, multiple arteries
2375	20	Secondary valvulotomy or commissurotomy (closed) (R.F.)
2376	20	Transaortic commissurotomy for aortic stenosis
2377	20	Valvulotomy or commissurotomy, with bypass
2380	25	Reconstructive coronary artery surgery
2383	20	Repair, ventricular aneurysm, without bypass (R.F.)

2384	20	Repair, ventricular aneurysm, with bypass (R.F.)
2386	20	Repair, I-A septal defect, using "Gross Well" (R.F.)
2387	20	using atrioseptopexy (R.F.)
2389	20	(primum), with bypass (R.F.)
2390	20	Suture, I-A septal defect, without bypass
2391	20	using cardiopulmonary bypass
2393	20	Repair, transposition of great vessels (R.F.)
2394	20	Repair, I-V septal defect, with bypass (R.F.)
2396	25	Total repair tetralogy of Fallot, with bypass (R.F.)
2403	20	Total repair, anomalous pulmonary veins (R.F.)
2404	20	Repair, partial, anomalous pulmonary veins (R.F.)
2410	20	Repair, congenital stenosis, aortic, with bypass (R.F.)
2411	20	Repair, congenital stenosis, mitral, without valve replacement (R.F.)
2414	25	Saphenous vein aorto-coronary bypass graft, single
2415	25	double
2416	25	triple
2417	12	Insertion and subsequent removal of intra-aortic balloon
2419	-	Not otherwise classified (I.C.)
		Arteries and Veins
		Incision
2420	6	Arterial embolectomy, neck, carotid
2424	20	Pulmonary embolectomy (R.F.)
2425	10	chest (R.F.)
2427	10	Arteriotomy, with removal of embolus aortic or iliac

2428	6	Arteriotomy, other (subclavian, brachial, mesenteric, etc.) (R.F.)
2429	10	Arteriotomy or venotomy for removal of thrombi or emboli, with patch graft (I.C.)
2430	5	extremity, femoral
		Venous thrombectomy, direct or with catheter
2440	10	Thrombectomy, vena cava and/or iliac, abdominal or thoracic (R.F.)
		Excision
		Excision and graft or direct repair
2450	10	Aneurysm or occlusive disease, carotid or axillary-brachial
2451	10	Repair or ligation, aneurysm (aneurysmorrhaphy) (R.F.)
2452	10	Excision, aneurysm, with hemograft or prosthesis, subclavian or innominate
2456	25	Excision, arch of aorta, with graft
2457	20	with valve replacement (R.F.)
2461	20	Excision, aneurysm, with homograft, thoracic aorta, with bypass (R.F.)
2463	20	Repair, thoracic or abdominal aorta, with bypass (R.F.)
2464	25	Repair, thoracic or abdominal aorta, with graft
2470	17	iliac
2471	10	femoral
2472	10	popliteal
2473	-	Popliteal aneurysm, without graft
2475	-	Excision/repair, arteriovenous fistula, neck or extremities (R.F.)
2476	-	chest (R.F.)

2477	-	abdomen (R.F.)
2478	20	Repair, coronary A-V fistula, with bypass (R.F.)
2480	-	Excision, arteriovenous aneurysm (R.F.)
2483	-	with thoracotomy (R.F.)
2484	-	with laparotomy (R.F.)
2481	17	Filipuncture: wiring of aneurysm of aorta (thoracic approach)
2482	4	extremity (R.F.)
2485	3	Excision, temporal artery (I.P.)
2486	3	Excision, segment of artery of extremity (R.F.)
2487	10	Excision, segment of vein of extremity (excluding varicosities) (R.F.)
2488	6	Excision, artery or vein segment, other than extremity (R.F.)
		Thromboendarterectomy, with or without patch graft
2490	10	Carotid endarterectomy, with patch graft
2494	10	Endarterectomy, with or without patch graft, vertebral (R.F.)
2495	10	subclavian (R.F.)
2496	10	axillary (R.F.)
2497	12	renal, unilaterial (R.F.)
2498	12	bilateral (R.F.)
2499	12	mesenteric (R.F.)
2501	17	Thromboendarterectomy, abdominal aorta, bilateral iliacs and common femorals (R.F.)
2502	17	abdominal aorta and unilateral iliac (R.F.)
2503	17	abdominal aorta and bilateral iliacs (R.F.)

2504	10	popliteal (R.F.)
2505	17	unilateral iliac and/or common femoral (R.F.)
2506	10	common femoral and superficial femoral to popliteal, unilateral (R.F.)
2507	17	superficial femoral and popliteal (R.F.)
2508	10	superficial femoral (R.F.)
		Bypass-graft, vein or synthetic
2510	10	Homograft or prosthesis, carotid
2516	20	aorto-iliac, any combination (R.F.)
2517	20	Homograft or prosthesis, aorto-femoral, unilateral (R.F.)
2518	20	bilateral (R.F.)
2519	17	aorto-mesenteric (R.F.)
2520	17	aorto-renal (R.F.)
2524	17	Homograft or prosthesis, iliac to popliteal
2528	10	common femoral to popliteal
2529	10	superficial femoral to popliteal
2532	17	femoro-femoral (R.F.)
2533	15	axillo-femoral, unilateral (R.F.)
2534	-	Homograft or prosthesis, other (R.F.)
2535	-	with femoro-femoral
		Exploration (not followed by surgical repair)
2548	-	Arteriotomy or venotomy, other (R.F.)

		Introduction
		Injection procedures for vascular radiography
		Intravenous
2561	4	Catheterization of the vera cora (I.P.)
2562	5	Injection for angiocardiograms (I.P.) (not allowed separately if performed as part of cardiac catheterization)
2563	5	Catheterization of the heart, unilateral (I.P.)
2567	5	bilateral (I.P.)
		Intra-arterial, intra-aortic
2568	-	Insertion of pulmonary artery catheter (e.g., Swann Ganz) for monitoring
2570	-	Venography, extremity, unilateral
2571	-	bilateral
2572	-	Venography, caval or branch (not to include adrenal or parathyroid)
2573	-	Venography, intraosseous
2574	4	Aortography, lumbar, direct (I.P.)
2575	4	retrograde, with catheter (I.P.)
		Selective vascular studies (not to include coronary catheterization; includes pulmonary arteriography and adrenal and parathyroid venography; excludes other venous studies)
2576	-	First selective catheterization
2577	-	First nonselective catheterization
2578	-	Additional selective, nonneuroarterial (not to exceed three)
2579	-	Additional selective, neuroarterial (not to exceed three)

2583	5	Selective coronary arteriography
2586	4	Arteriography, peripheral, unilateral (I.P.)
2587	4	bilateral
2588	-	Cardiac catheterization, complete (includes coronary angiography, pressure measurement, and interpretation)
		Venous
2600	-	Intravenous fluid therapy, under age two (I.P.)
2605	-	Vein cutdown for intravenous therapy by consultant
2611	-	Exchange transfusion, initial
2613	-	subsequent
2614	-	Intrauterine fetal transfusion
2615	-	Injection of sclerosing agent, single vein (R.F.)
2616	-	multiple veins (R.F.)
2617	-	Subsequent injection of single vein
2618	-	multiple veins (R.F.)
2619	-	Placement of indwelling central venous catheter in infants for long-term parenteral nutrition (lifeline), initial (R.F.)
2620	-	subsequent (R.F.)
2621	-	Placement of indwelling central venous catheter in adults for long-term parenteral nutrition (lifeline), initial
2622	-	subsequent
		Arterial
2631	-	Arterial catheterization (I.P.) (R.F.)
2632	-	Cutdown (R.F.)

		Intravascular cannulization
2641	-	Surgical insertion of continuous arteriovenous shunt for hemodialysis (I.P.)
2642	4	Secondary revision of A-V shunt, temporary (I.P.) (R.F.)
2643	5	Creation of permanent A-V fistula for dialysis (I.P.) (R.F.)
2644	5	Revision of permanent A-V fistula (I.P.) (R.F.)
		Repair
2650	20	Pulmonary banding (R.F.)
2651	25	Repair, aortic arch anomalies (R.F.)
2657	25	Excision, coarctation of aorta, with or without graft
2660	25	Pulmonary innominate or subclavian anastomosis (Blalock)
2661	25	Pulmonary aortic anastomosis (Potts)
2663	20	Vena cava-pulmonary artery anastomosis (Glenn) (R.F.)
2664	20	Vena cava-mesenteric anastomosis (R.F.)
2667	-	Arterial shunt, other (I.C.)
2668	15	Ligation of ductus arteriosus
2670	15	Porto-caval anastomosis
2671	15	Spleno-renal anastomosis
2675	-	Plastic operation for repair of arteriovenous aneurysm (R.F.)
		Suture
2680	5	Repair, wound or injury to vein, neck (I.P.) (R.F.)
2681	-	chest (R.F.)
2682	-	abdomen (R.F.)
2683	-	extremity (I.C.)
2687	6	Ligation of inferior vena cava

2688	-	Insertion of vena cava umbrella
2694	-	Ligation of veins, other, unilateral or bilateral (S.O.) (R.F.)
2700	3	Division and complete stripping of long or short saphenous veins, unilateral (S.O.)
2701	3	bilateral (S.O.)
2704	3	Ligation, division, and/or stripping, excision of ulcer, with or without graft, unilateral (S.O.) (I.C.)
2705	3	bilateral (S.O.) (R.F.)
2706	3	Division and complete stripping of long and short saphenous veins, unilateral (S.O.) (see Service Code 2717 for bilateral)
2708	3	Division of long and/or short saphenous veins, with excision of masses of tortuous varicose veins, unilateral (S.O.) (R.F.)
2709	3	bilateral (S.O.) (R.F.)
2712	3	Ligation or excision of minor vein (S.O.) (R.F.)
2713	3	Division and complete stripping of long or short saphenous veins, with subfacial interruption of communicating veins, unilateral (S.O.)
2714	3	bilateral (S.O.)
2715	3	Division and complete stripping of long and short saphenous veins, with subfacial interruption of communicating veins, unilateral (S.O.)
2716	3	bilateral (S.O.)
2717	3	Division and complete stripping of long and short saphenous veins, bilateral (S.O.) (see Service Code 2706 for unilateral)
2724	10	Arteriorrhaphy, suture of wound or injury of artery (I.P.) (R.F.)
2730	5	Ligation of carotid artery
2733	5	Occlusion of carotid artery by silverstone clamp

2734	-	Clamp adjustment (maximum of one per day)
2736	-	Clamp adjustment, maximum
2735	3	Ligation of femoral artery (R.F.)
2737	3	Ligation of internal iliac artery (R.F.)
2748	3	Ligation of artery, other (R.F.)
2749	-	Not otherwise classified (I.C.)

HEMIC AND LYMPHATIC SYSTEMS

Spleen

Excision

2750	7	Splenectomy (I.P.)
2753	-	Splenic puncture (I.P.) (R.F.)

Introduction

2760	-	Splenoportogram

Repair

2775	7	Suture repair of wound or injury of spleen (R.F.)
2779	-	Not otherwise classified (I.C.)

Lymph Nodes and Lymphatic Channels

Incision

2780	3	Drainage of lymph node abscess or lymphadenitis

Excision

2790	3	Biopsy of lymph node (I.P.)
2792	4	Anterior scalene (I.P.)
2797	3	Excision, lymph node (I.P.) (R.F.)
2798	3	Simple excision of chain of lymph nodes for tuberculosis, etc.

		Radical lymphadenectomy, radical resection of lymph nodes
2810	6	Upper neck, unilateral
2811	6	bilateral
2815	6	Cervical, complete (other than upper neck), unilateral
2816	6	bilateral
2818	3	Axilla, unilateral
2819	3	bilateral
2825	3	Groin, unilateral, superficial
2826	3	bilateral
2827	5	Deep, pelvic nodes, unilateral
2828	5	bilateral
2835	6	Radical periaortic, mesenteric, and retroperitoneal node dissection, unilateral
2838	6	bilateral (R.F.)
		Introduction
2840	-	Lymphangiography, unilateral
2841	-	bilateral
2842	-	under age 12, unilateral
2843	-	under age 12, bilateral
2845	-	Sialography
2849	-	Not otherwise classified (I.C.)
		Mediastinum
		Incision
2850	13	Mediastinotomy, with exploration or drainage, cervical
2851	13	anterior or posterior

2853	13	cervical for drainage or exploration (other than excision of scalene nodes) (R.F.)
2855	13	foreign body removal, cervical (R.F.)
		Excision
2860	13	Excision of mediastinal cyst
2861	13	Excision of mediastinal tumor
2866	13	Ligation of thoracic duct, thoracic approach (R.F.)
		Endoscopy
2870	4	Mediastinoscopy, with or without biopsy (R.F.)
		Repair
2880	13	Thoracic duct by suture (I.P.)
2881	13	Anastomosis thoracic duct (I.P.)
2890	6	Tracheal resection and reconstruction for obstructive disease of the trachea, cervical
2891	13	Cervicomediastinal
2892	13	Intrathoracic, simple
2893	13	complex (such as extended dissection or carinal removal and bronchial reimplantation)
2894	13	Cervicomediastinal, thoracic
2895	13	with cutaneous prosthetic reconstruction, first stage
2896	13	with extended mediastinal dissection
2897	13	with cutaneous prosthetic reconstruction, second stage
2898	13	Mediastinal tracheostomy, with extended dissection and resection
2899	-	Not otherwise classified (I.C.)

DIGESTIVE SYSTEM

Mouth

Incision

2900	5	Drainage of sublingual abscess (R.F.)
2902	5	Drainage of submucosal abscess, not including alveolar (R.F.)
2903	-	Biopsy of buccal mucosa (R.F.)
2904	5	Drainage of Ludwig's angina, nonhospitalized (R.F.)
2905	5	inpatient
2906	4	Excision of local lesion of buccal mucosa (R.F.)
2907	4	Excision of malignant lesion of buccal mucosa (R.F.)
2908	8	Excision of intraoral tumor, with jaw resection and radical neck dissection in continuity (R.F.)
2909	-	Stomatoplasty, plastic repair or reconstruction on mouth (R.F.)
2910	-	Abbe flap (R.F.)
2901	-	Release of flap (R.F.)
2912	-	Not otherwise classified (I.C.)

Lips

Excision

2911	4	Local excision of lesion of lips
2915	4	V-excision of lesion of lips
2916	4	Resection of more than one-fourth lip
2917	4	Resection of malignant lesion of lip, with primary closure (I.C.)
2918	4	with plastic repair, flap (R.F.)
2919	4	skin graft (R.F.)

		Repair (cheiloplasty)
2920	8	Plastic repair of harelip, primary, unilateral, one stage
2921	8	bilateral, one stage
2922	8	two stages, per stage
2923	3	secondary, local revision, unilateral or bilateral (R.F.)
2924	8	Repair of harelip by re-creation of defect and reclosure, unilateral
2925	8	bilateral (I.C.)
2927	4	Cheiloplasty, plastic or reconstruction operation on lip (P.A.) (I.C.)
2928	4	Secondary plastic repair of lip (P.A.) (I.C.)
2929	-	Not otherwise classified (I.C.)
		Tongue
		Incision (glossotomy)
2930	5	Drainage of lingual abscess (R.F.)
2931	4	Removal of foreign body from tongue (R.F.)
2933	-	Release of tongue tie (I.P.)
		Excision (glossectomy)
2940	4	Biopsy of tongue (I.P.)
2941	3	Local excision of lesion of tongue
2942	4	Glossorrhaphy: suture of tongue wound or injury (R.F.)
2943	-	Glossorrhaphy, partial, less than one-half tongue
2944	8	Partial glossectomy or hemiglossectomy (electro-coagulation)
2945	8	Complete or total glossectomy

2948	4	Glossoplasty: plastic operation on tongue (R.F.)
2949	-	Not otherwise classified (I.C.)
		Teeth and Gums
		Incision
2960	4	Drainage of alveolar abscess, acute with cellulitis-oral approach, inpatient only
2961	4	extraoral (R.F.)
2962	-	Drainage of dentigerous cyst (I.P.)
2963	4	Removal of tooth root from antrum (R.F.)
2964	4	Ridge extension (R.F.)
2965	3	Cuspid exposure for orthodontic movement
2966	4	Surgical movement of impacted tooth
2967	4	Dental root resection: apicoectomy, one, in conjunction with other surgery
2968	4	more than one, as individual procedure (R.F.)
		Excision
2969	4	Excision, incisive canal cyst (R.F.)
2970	4	Excision, adamantinoma (ameloblastoma) (R.F.)
2971	-	Partial bony impaction (R.F.)
2972	-	each additional
2973	4	Odontectomy, bony impaction, with or without alveolectomy
2974	-	subsequent
2975	-	Soft-tissue impaction
2976	-	Subsequent soft-tissue impaction (R.F.)
2977	4	Tooth extraction

2978	4	each additional tooth (R.F.)
2979	4	Excision, cystic lesion of jaw (R.F.)
2980	3	Excision, torus palatinus
2981	3	Excision, mandibular tori
2982	4	Excision, radicular cyst, involving area of one through four teeth
2983	4	involving area greater than four teeth
2984	4	Excision, dentigerous cyst or other benign lesion of jaw (R.F.)
2985	3	Excision, cystic hypertrophied tissue edentulous ridge (I.P.) (R.F.)
2986	4	Gingivectomy, per quadrant (I.P.)
2988	8	Radical neck dissection with segmental mandibulectomy
2989	-	Not otherwise classified (I.C.)
		Suture
2990	3	Suture of gum (I.P.)
2991	-	Excision, benign lesion of gum (I.P.)
2992	-	Excision, malignant lesion of gum or jaw (R.F.)
2993	-	Frenectomy, labial (I.P.) (R.F.)
2994	-	Alveolectomy, with more than six extractions
2995	4	Alveoplasty of edentulous mouth, one jaw
2996	4	both jaws
2997	-	Repair of accidental damage to teeth (R.F.)
2998	4	Vestibuloplasty, with skin graft for atrophic mandible (R.F.)
2999	4	Repair of alveolar fracture, not including treatment of displaced or broken teeth (R.F.)

Palate and Uvula

Incision

3000	5	Incision and drainage of palate abscess (R.F.)

Excision

3010	4	Biopsy of palate (I.P.)
3011	6	Resection of palate or wide excision of lesion of palate (R.F.)
3012	4	Excision, local lesion of palate
3013	4	with graft or flap closure (R.F.)
3015	4	Uvulectomy: excision of uvula (I.P.)

Repair

3020	8	Repair of partial cleft palate
3021	8	Repair of complete cleft palate including alveolar ridge
3023	-	secondary revision (R.F.)
3024	8	secondary lengthening procedure
3025	8	attachment pharyngeal flap

Suture

3028	3	Suture of palate wound or injury (R.F.)
3029	-	Not otherwise classified (I.C.)

Salivary Glands and Ducts

Incision

3030	4	Drainage of parotid abscess (R.F.)
3035	4	Sialolithotomy: removal of salivary calculus, intraoral, hospitalized
3036	4	extraoral
3037	4	intraoral, office or outpatient department (R.F.)

		Excision
3041	4	Biopsy of salivary gland (I.P.)
3042	4	Excision, ranula
3043	4	Excision, parotid tumor
3045	5	Excision, parotid gland with dissection of facial nerve
3046	5	with sacrifice of facial nerve
3047	5	Excision, submaxillary salivary gland and/or tumor
3048	5	Subtotal parotidectomy, with nerve dissection and preservation (R.F.)
		Repair
3050	5	Plastic repair of salivary duct, sialodochoplasty (R.F.)
3059	5	with stint (R.F.)
		Suture
3070	5	Closure of salivary fistula
		Manipulation
3080	4	Dilation of salivary duct, ptyalectasis (I.P.)
3089	-	Not otherwise classified (I.C.)
		Pharynx, Adenoids, and Tonsils
		Incision
3090	5	Drainage of peritonsillar abscess
3095	5	Drainage of retropharyngeal abscess, internal approach (R.F.)
3096	5	external approach
3098	6	Nasopharyngeal application of radium, one or more treatments (I.P.)

		Excision
3100	4	Biopsy of pharynx (I.P.)
3101	4	Biopsy of nasopharynx
3103	6	Excision, pharyngoesophageal diverticulum
3105	4	Excision, branchial cyst or vestige, superficial
3106	4	deep, radical
3107	4	Tonsillectomy, with or without adenoidectomy (S.O.)
3110	4	Adenoidectomy (S.O.) (I.P.)
3111	4	Excision, tonsil tag, unilateral (I.P.)
3115	4	Excision, lingual tonsil (I.P.)
3116	4	Excision, nasopharyngeal fibroma (R.F.)
3117	4	Excision, nasopharyngeal bursa, cyst, or benign tumor (R.F.)
		Suture
3120	4	Suture of external wound or injury of pharynx (R.F.)
3122	4	Control of secondary hemorrhage in hospital, following tonsil surgery by operating surgeon
3123	4	by consultant
3127	4	Control of secondary oral or nasopharyngeal hemorrhage in hospital by operating surgeon
3128	4	by consultant
		Repair
3130	6	Pharyngoplasty, plastic or reconstruction operation, pharynx (I.C.)
3139	-	Not otherwise classified (I.C.)

Esophagus

Incision

3140		Esophagotomy, cervical
3142	3	intrathoracic

Excision

3151	3	Esophagectomy, resection of esophagus, transpleural or extrapleural
3153	3	Local excision of esophagus with end-to-end anastomosis
3154	13	Esophagogastrectomy: combined thoracoabdominal
3155	8	Esophageal diverticulum or fistula, transcervical (R.F.)
3156	13	Intrathoracic esophageal diverticulum (R.F.)
3157	8	Excision, intramural tumor of esophagus, cervical (R.F.)
3158	13	intrathoracic (R.F.)

Endoscopy

3160	4	Esophagoscopy, diagnostic
3163	4	with biopsy
3164	4	with foreign body removal
3165	4	with dilation
3166	4	Fiber optic esophagoscopy

Repair

3170	13	Esophagoplasty: plastic repair or reconstruction of esophagus
3172	13	Colon interposition with gastrocolic anastomosis, resection of colon and iliocolic anastomosis
3173	13	Esophagogastrostomy (cardioplasty)
3175	13	Esophagomyotomy (Heller)

3177	13	Esophagojejunostomy or duodenostomy
3178	13	Esophagostomy: fistulization of esophagus, external
		Suture
3180	13	Transthoracoesophageal suture of bleeding esophageal varices (R.F.)
3183	10	Suture of esophageal wound, injury, or rupture, cervical approach
3184	13	intrathoracic approach
3185	7	Closure of esophagostomy or other external esophageal fistula, cervical
3186	13	thoracic
		Manipulation
3190	4	Dilation of esophagus by sound, bougie, or bag (I.P.)
3191	4	subsequent dilation of esophagus (R.F.)

3193	-	Nonradiological esophageal motility studies
3194	-	Acid perfusion study
3195	-	Pneumatic dilation of cardia for achalasia
3197	4	Esophagogastric tamponade for hemorrhage (Sengstaaken) (R.F.)
3199	-	Not otherwise classified (I.C.)
		Stomach
		Incision
3200	7	Gastrotomy, with exploration or foreign body removal
3203	8	Pyloromyotomy: cutting of pyloric muscle (Fredet-Ramstedt operation)
		Excision
3210	-	Peroral tissue biopsy, stomach (under age five, I.C.)
3211	7	Biopsy of stomach, with laparotomy (I.P.)
3212	7	Local excision of stomach ulcer or benign neoplasm (I.P.)
3214	7	Total gastrectomy, with vagotomy
3215	7	Subtotal gastrectomy
3216	7	Subtotal gastrectomy, with vagotomy
3217	-	Antrum of stomach (secondary procedure)
3218	7	Pyloroplasty, with vagotomy or vagectomy
		Endoscopy
3220	-	Gastroscopy, diagnostic (I.P.)
3221	-	with biopsy (I.P.)
3224	-	Gastric lavage to remove poison (I.P.)
3225	-	Fiber optic gastroduodenoscopy (I.P.)

		Suture
3230	7	Pyloroplasty (see also Service Code 3218)
3231	7	Gastroduodenostomy
3232	7	Gastrojejunostomy
3233	7	with partial vagectomy, vagotomy
3234	6	Interposition of jejunum (Poth procedure) for dumping syndrome (R.F.)
3235	7	Gastrostomy for feeding
3238	7	Gastrorrhaphy: suture of perforated gastric ulcer, wound, or injury
3240	7	Closure or taking down of gastroduodenal anastomosis (gastroduodenostomy)
3242	-	Closure or taking down of gastrojejunal anastomosis (gastrojejunostomy)
3245	5	Closure of gastrostomy
3246	7	Closure of gastrocolic fistula (R.F.)
3247	7	Closure of gastrojejunocolic fistula (R.F.)
3249	-	Not otherwise classified (I.C.)
		Intestine (except Rectum)
		Incision
3250	6	Enterolysis: freeing of intestinal adhesions (I.P.)
3255	6	Enterotomy, with exploration or foreign body removal, small bowel (I.P.)
3256	6	large bowel (I.P.)
3257	6	Exteriorization of intestine, preliminary to resection: first-stage Mikulicz resection of intestine
		Excision
3260	-	Peroral tissue biopsy, intestine (under age five, I.C.)

3261	6	Excision, one or more intestinal lesions not requiring anastomosis, exteriorization, or fistulization
3263	6	Enterectomy: resection of small intestine, with anastomosis
3267	6	Enteroenterostomy: anastomosis of intestines (I.P.)
3268	-	under age two (I.P.)
3270	6	Colectomy, partial, one or two stages, with anastomosis and with or without proximal colostomy
3272	8	total, one or two stages, with or without ileostomy or anastomosis
3273	8	total, one or two stages, with total proctectomy and ileostomy
		Enterostomy, external fistulization of intestine
3278	6	Small (ileostomy or jejunostomy) (I.P.)
3280	6	Large (colostomy) (I.P.)
3281	8	Small or large, for ulcerative colitis
3283	6	Reduction of volvulus, intussusception, internal hernia (by laparotomy) (I.P.)
3285	4	Revision of colostomy (I.P.)
3286	4	Revision of colostomy and peristomal herniation (I.P.) (R.F.)
3287	5	Relocation of colostomy stoma (R.F.)
		Repair
3290	6	Cecopexy: fixation of cecum to abdominal wall (I.P.)
3293	6	Sigmoidopexy (I.P.) (R.F.)
		Suture
3300	6	Suture of intestine (enterorrhaphy), large or small, for perforated ulcer, wound, injury, or rupture (I.P.)
3305	6	Closure of enterostomy, large or small intestine (I.P.)

3307	6	Closure of fecal fistula (I.P.) (R.F.)
3315	6	Intestinal plication, complete, Noble, Ladd (R.F.)
3319	-	Not otherwise classified (I.C.)

Meckel's Diverticulum and the Mesentery

Excision

3320	6	Meckel's diverticulum (diverticulectomy)
3325	6	Lesion of mesentery (I.P.) (R.F.)

Suture

3330	5	Suture of mesentery (I.P.) (R.F.)
3339	-	Not otherwise classified (I.C.)

Appendix

Incision

3340	5	Incision and drainage of appendical abscess (I.P.)

Excision

3350	5	Appendectomy (I.P.)
3349	-	Not otherwise classified (I.C.)

Rectum

Incision

3370	4	Transrectal incision and drainage of pelvic abscess (R.F.)
3373	3	Incision and drainage of submucous abscess
3376	3	Incision and drainage of supralevator abscess

Excision

3381	4	Full thickness biopsy for Hirsch-Sprungs disease (R.F.)
3382	4	Local excision of lesion of rectum (R.F.)

3385	8	Complete proctectomy, combined abdominoperineal, one or two stages
3386	8	Complete proctectomy for congenital megacolon
3387	4	Excision, rectal procidentia (I.P.)
3391	4	Perineal excision of recurrent malignant tumor (R.F.)
3392	4	Excision or fulguration of malignant lesion (I.C.)
3394	-	Electroexcision of cancer of the rectum, initial
3395	-	second
3396	-	third
3397	-	Cryosurgery, initial
3398	-	second
		Endoscopy
3400	-	Proctosigmoidoscopy, diagnostic (I.P.)
3402	4	including biopsy (I.P.)
3406	4	with removal of papillomas or polyps (I.P.)
3407	-	Colonoscopy (I.P.) (R.F.)
3410	-	Proctoscopy, with insertion of radioactive substance (I.P.) (R.F.)
3420	4	Proctoplasty, perineal, for stricture
3422	4	for procidentia
3427	6	Proctopexy, abdominal, for prolapse (Moschocowitz)
		Suture
3430	4	Closure of rectovesical fistula
3435	4	Closure of rectourethral fistula
3436	4	Closure of rectovaginal fistula

		Manipulation
3440	-	Reduction of prolapse of rectum
3445	-	Instrumental dilation of rectal stricture
3449	-	Not otherwise classified (I.C.)
		Anus
		Incision
3450	4	Fistulotomy
3451	3	Undercutting for pruritus ani (modified Ball)
3452	3	Incision of hemorrhoid, thrombosed external (R.F.)
3455	3	Incision and drainage of ischiorectal abscess
3456	3	Incision and drainage of perianal abscess
3457	3	Incision and drainage of ischiorectal abscess, with fistulotomy or fistulectomy
3463	4	Sphincterotomy, anal: diversion of anal sphincter
		Excision
3470	3	Fissurectomy with or without sphincterotomy (I.P.)
3471	4	Cryptectomy, single or multiple (I.P.)
3473	-	Papillectomy, single or multiple
3474	3	Excision of external hemorrhoidal tags
3475	4	Hemorrhoidectomy, external only
3476	4	internal and external (S.O.)
		Multiple procedures performed at same time for hemorrhoids, fissure fistula, crypts, minor prolapse
3480	4	Fistulectomy
3482	4	Fistulectomy, second stage
3484	4	Fistulotomy or fistulectomy and hemorrhoidectomy, internal (S.O.)

3485	4	Fissurectomy and hemorrhoidectomy, internal (S.O.)
3486	4	Fistulotomy or fistulectomy with sphincteroplasty (R.F.)
3487	3	Enucleation of external thrombotic hemorrhoid
3488	3	Condyloma, single or multiple, internal
3489	4	Fistulotomy or fistulectomy and hemorrhoidectomy, external (see Service Code 3484 for internal)
3490	4	internal and external (see Service Code 3484 for internal only)
3492	4	Fissurectomy and hemorrhoidectomy, external (see Service Code 3485 for internal)
3493	4	internal and external (see Service Code 3485 for internal only)
3496	3	Excision, sessile tumor three inches up in anal canal including margin of normal mucosa; mucosa closure by running sutures
3497	3	Snare removal papillary adenoma rectal wall in three of four stages, first stage
3498	3	subsequent stages
		Introduction
3500	-	Injection of hemorrhoids (on special contracts only) (R.F.)
3505	-	Alcohol injection for pruritus ani (R.F.)
		Endoscopy
3510	-	Anoscopy, with or without biopsy (I.P.)
3515	-	with removal of a foreign body (I.P.)
		Repair
3520	4	Anoplasty: plastic operation for imperforate anus or stricture (I.C.)
3522	3	circular excision of anal mucosa (Whitehead operation) for prolapse together with hemorrhoidectomy (I.C.)

3524	4	Thiersch procedure for incontinence and/or prolapse
3525	7	Construction of anus for congenital absence
3526	10	Combined abdominoperineal approach
3530	4	Sphincteroplasty, anal: plastic operation for incontinence
		Destruction
3541	4	Treatment of condylomata by electrocoagulation, in hospital under general anesthesia (I.P.)
3542	-	Treatment of condylomata by local application of liquid nitrogen in office, initial (I.P.)
3543	-	subsequent (maximum of five per 12-month period) (I.P.)
3545	3	Curettage or cauterization of anal fissure, including dilation of anal sphincter (I.P.)
		Manipulation
3550	3	Dilation of sphincter under anesthesia (I.P.) (R.F.)
3559	-	Not otherwise classified (I.C.)
		Liver
		Incision
3560	-	Aspiration biopsy of liver (I.P.)
3563	8	Incision and drainage of liver abscess (I.P.) (R.F.)
3565	-	Cholangiography, percutaneous
		Excision
3570	6	Biopsy of liver (by laparotomy) (I.P.)
3575	13	Hepatectomy, partial: resection of liver
3576	13	Hepatectomy, total lobectomy
		Repair
3580	8	Marsupialization of cyst or abscess of liver

Suture

3590	8	Hepatorrhaphy: suture of liver wound or injury
3599	-	Not otherwise classified (I.C.)

Biliary Tract

Incision

3600	7	Hepaticotomy (I.P.) or hepaticostomy with exploration, drainage, or removal of calculus (R.F.)
3601	7	Choledochotomy or choledochostomy, with exploration, drainage, or removal of calculus, with or without cholecystotomy
3605	7	Duodenocholedochotomy: transduodenal choledocholithotomy
3607	6	Cholecystotomy or cholecystostomy with exploration, drainage, or removal of calculus

Excision

3620	7	Cholecystectomy
3621	7	with cholangiogram
3622	7	with open exploration of common duct
3630	-	Radical excision of ampulla of vater, with resection of duodenum and portion of pancreas, gastrojejunostomy and anastomosis of biliary tract to alimentary tract, one or two stages (R.F.)

Repair

3642	7	Anastomosis of gall bladder to stomach or intestine
3644	7	Intrahepatic exposure and exploration or anastomosis of bile ducts
3645	7	Anastomosis of bile duct to stomach or intestine
3646	7	Choledochoplasty: plastic repair or reconstruction of bile ducts
3647	7	Implantation of biliary fistulous tract into stomach or intestine

3659	-	Not otherwise classified (I.C.)

Pancreas

Incision

3660	7	Pancreatotomy for drainage of pancreatitis, abscess, or pseudocyst
3663	7	for removal of calculus

Excision

3672	8	Pancreatectomy with duodenotomy (R.F.)
3673	7	Resection of body or tail of pancreas, with or without splenectomy
3675	7	Pancreatico-duodenectomy

Repair

3680	7	Marsupialization of cyst of pancreas (I.P.)
3681	7	with anastomosis to intestine (I.P.) (R.F.)
3683	7	Pancreatico-gastrostomy for pseudocyst (I.P.) (R.F.)
3689	-	Not otherwise classified (I.C.)

Abdomen, Peritoneum, and Omentum

Incision

3690	5	Laparotomy: exploratory celiotomy
3691	6	Reopening of recent laparotomy incision for exploration, removal of hematoma, control of bleeding, etc. (R.F.)
3692	6	Retroperitoneal exploration (I.P.) (R.F.)
3693	5	Drainage of peritoneal abscess or localized peritonitis exclusive of appendical abscess
3694	6	Subdiaphragmatic or subphrenic abscess, one or two stages
3695	6	Retroperitoneal abscess

3696	-	Peritoneocentesis: abdominal paracentesis, initial
3697	-	subsequent (R.F.)
3698	6	Removal of peritoneal foreign body (R.F.)
3700	4	Inguinal exploration, extraperitoneal, without hernia repair (R.F.)
3703	5	Laparotomy for implantation of silicone peritoneal tube (R.F.)
		Excision
3710	7	Excision, retroperitoneal tumor (R.F.)
3713	6	Umbilectomy: omphalectomy, excision of umbilicus (I.P.)
3715	6	Omentectomy: epiploiectomy, resection of omentum (I.P.)
		Endoscopy
3720	-	Peritoneoscopy, with or without biopsy
		Introduction
3730	-	Pneumoperitoneum: intraperitoneal injection of air, initial
3731	-	subsequent (R.F.)
3735	3	Reinsertion of gastrostomy or t-tube under anesthesia (R.F.)
3738	-	Insertion of radioactive substance, abdomen, percutaneous needle (R.F.)
		Hernioplasty, herniorrhaphy, herniotomy (hernia repair with fascial graft commands an additional fee; use Service Code 3744 for unilateral and Service Code 3749 for bilateral
		Repair
3740	4	Hernia, inguinal, unilateral
3741	4	with appendectomy or orchiectomy
3742	4	with excision of hydrocele or varicocele

3743	4	recurrent
3745	4	Hernia, inguinal, bilateral
3746	4	with appendectomy or orchiectomy
3747	4	with excision of hydrocele or varicocele
3748	4	recurrent
3750	4	Repair of lumbar or other muscle hernia (R.F.)
3751	4	Hernia, femoral, unilateral
3752	4	recurrent
3753	4	with appendectomy or orchiectomy
3754	4	with excision of hydrocele or varicocele
3755	4	Hernia, femoral, bilateral
3756	4	recurrent
3757	4	with appendectomy or orchiectomy
3758	4	with excision of hydrocele or varicocele
3760	5	Ventral, incisional (I.P.) (R.F.)
3762	4	Epigastric
3764	4	Umbilical (I.P.)
3765	4	recurrent (R.F.)
3767	10	Omphalocele
3768	5	Staged repair, per stage (I.C.)
3771	9	Repair of diaphragmatic hernia, abdominal (I.P.)
3773	13	transthoracic (I.P.) (R.F.)
3777	5	Reduction of torsion of omentum (I.P.) (R.F.)

Suture

3780	6	Secondary suture of abdominal wall for evisceration or disruption (R.F.)
3790	-	Debridement of wound or injury to abdominal wall (R.F.)
3793	6	Resection of peritoneal adhesions (I.P.) (R.F.)
3799	-	Not otherwise classified (I.C.)

URINARY SYSTEM

Kidney

Incision

3800	-	Aspiration of renal cyst or renal pelvis (I.P.)
3801	-	Renal cyst puncture and contrast (if done at same time as arteriography, to be regarded as an additional selective study; see Service Code 2579)
3802	6	Drainage of perirenal abscess (I.P.)
3804	6	Nephrostomy, with drainage (I.P.)
3805	6	Exploration, with or without biopsy (I.P.)
3806	6	Nephrolithotomy, with removal of calculus (I.P.)
3811	6	Division or transection of aberrant renal vessels (I.P.)
3812	6	Pyelotomy, with exploration (I.P.)
3813	6	Pyelostomy, with drainage (I.P.)
3814	6	Pyelolithotomy (I.P.)

Excision

3820	-	Renal biopsy (by trocar or needle) (I.P.)
3825	6	Nephrectomy, with or without partial ureterectomy
3826	6	Radical nephrectomy including regional lymph nodes
3827	6	Nephrectomy, with total ureterectomy

3833	6	partial (heminephrectomy)
3837	7	Excision, cyst of kidney
		Renal transplantation
3851	7	Kidney transplant
		Introduction
3861	-	Pneumography, retroperitoneal
3862	-	Injection of dye through nephrostomy tube for X ray (R.F.)
3865	-	Urography, antegrade, pyelostogram or nephrostogram
3866	-	Loopogram
3867	-	Change of nephrostomy tube (R.F.)
3868	6	Fluoroscopic control (R.F.)
		Repair
3870	6	Pyeloplasty: plastic operation on renal pelvis, with or without plastic operation on ureter
		Suture
3880	7	Nephrorrhaphy: suture of kidney wound or injury
3882	6	Closure of renal colic fistula
3883	6	Symphysiotomy for horseshoe kidney
3884	6	Closure of nephrostomy, pyelostomy, or other renal fistula
3889	-	Not otherwise classified (I.C.)
		Ureter
		Incision
3890	6	Ureterotomy, with exploration or drainage, abdominal approach (I.P.)
3896	6	Ureterolithotomy, abdominal or retroperitoneal approach

3898	5	Drainage of retroperitoneal urinary extravasation (R.F.)
		Excision
3900	6	Ureterectomy, complete or partial (I.P.)
		Repair
3910	6	Ureteroplasty: plastic operation on ureter (stricture)
3915	6	Ureteropyelostomy: anastomosis of ureter and renal pelvis
3920	6	Ureterocystostomy: anastomosis of ureter to bladder, unilateral
3921	6	bilateral
3924	6	Ureteroenterostomy: anastomosis of ureter to intestine, unilateral
3925	6	bilateral
3926	6	Construction of substitute bladder with bowel segment, including ureterointestinal anastomosis
3929	5	Revision of substitute bladder, with or without ureteral anastomosis (see also Service Code 4016) (R.F.)
3930	-	plus bowel shortening (R.F.)
3931	-	plus ureteral anastomosis, unilateral (R.F.)
3932	-	plus ureteral anastomosis, bilateral (R.F.)
3933	-	Bladder tap for culture
3935	6	Ureterostomy: transplantation of ureter to skin, unilateral
3936	6	bilateral
		Suture
3940	6	Ureterorrhaphy: suture of ureter (I.P.) (R.F.)
3942	6	Repair of ureteral fistula (I.P.) (R.F.)
3949	-	Not otherwise classified (I.C.)

Bladder

Incision

3951	-	Trocar aspiration of bladder (R.F.)
3955	5	Cystotomy, with exploration, fulguration, or insertion of radioactive substance, with or without biopsy
3960	5	Cystostomy, with drainage
3963	5	Cystolithotomy
3965	5	Drainage of perivesical or perivesical space abscess (R.F.)

Excision

3970	5	Excision, urachal cyst or sinus (R.F.)
3971	5	Suprapubic resection of bladder, neck (R.F.)
3972	5	Excision, bladder diverticulum (I.P.)
3973	5	Excision, bladder tumor
3975	6	Suprapubic excision of ureterocele
3980	6	Cystectomy, segmental resection
3982	8	complete, without transplant of ureters (R.F.)
3984	-	complete, with construction of substitute bladder with bowel segment including ureterointestinal anastomosis, two surgeons
3985	8	complete, with transplantation of ureters
3987	8	complete, with construction of substitute bladder with bowel segment including ureterointestinal anastomosis, one surgeon

Introduction

3996	-	Cystometrogram, alone (I.P.)
3997	-	Urethrocystography, voiding or retrograde
3998	-	Voiding pressure studies, bladder pressures only (I.P.) (R.F.)

3999	-	plus urethral pressures (I.P.) (R.F.)
4007	-	Vasography
		Repair
4000	6	Partial excision of bladder neck, with Y-V plasty (R.F.)
4001	6	Bladder neck resection, with reimplantation of one ureter (R.F.)
4002	6	both ureters (R.F.)
4003	3	Marshall-Machetti operation for urinary incontinence
4004	3	Repair of stress incontinence, including urethrocele (R.F.)
4005	5	Cystorrhaphy: suture of bladder, injury or rupture
4008	3	Closure of cystostomy or external fistula of bladder (R.F.)
4010	4	Closure of vesicovaginal fistula
4011	4	transvesical approach
4012	4	Closure of vesicouterine fistula (for closure of vesico-rectal, see Service Code 3430)
4013	-	Closure of extrophy of bladder (R.F.)
4014	-	with urethral implantation (R.F.)
4016	4	Revision of substitute bladder stoma (see also Service Code 3929) (R.F.)
4017	5	Construction of bladder flap to skin (lapides) (R.F.)
4018	6	Construction of bladder flap, internal, with resection of lower ureter and reanastomosis (R.F.)
4019	-	Not otherwise classified (I.C.)
		Cystoscopy, Urethroscopy, Cystourethroscopy
		Endoscopy
4020	3	Cystoscopy, diagnostic (I.P.)

4022	3	with ureteral catheterization (I.P.)
4028	3	Howard or Stamey test (I.P.)
4031	3	Urethroscopy, diagnostic (I.P.)
4032	3	with removal of calculus or foreign body
4033	3	with internal urethrotomy
4034	3	with fulguration of posterior urethra
4039	-	Not otherwise classified (I.C.)

Transurethral Surgery
(Urethra, Prostate, Bladder, Ureter)

Endoscopy

4040	3	Cystourethroscopy, with biopsy (I.P.)
4043	3	with fulguration of minor lesion of bladder (I.P.)
4045	3	with fulguration or resection of small bladder tumor (0.5-3.0 centimeters) (I.P.)
4046	3	with fulguration or resection of medium bladder tumor (2.0-5.0 centimeters) (I.P.)
4047	3	with fulguration or resection of large bladder tumor (I.P.)
4048	3	with insertion of radioactive substance, with biopsy or fulguration (I.P.)
4052	3	Cystoscopy, with internal urethrotomy for stricture or contracture of bladder neck (female) (I.P.)
4056	3	with ureteral meatotomy (I.P.)
4058	3	Resection or fulguration of ureterocele (I.P.)
4060	3	Cystoscopic removal of foreign body (I.P.)
4065	3	ureteral dilation with stone removal (I.P.)
4066	3	with stone manipulation, without removal (I.P.)
4070	4	Transurethral electroresection of vesical neck (female) (I.P.)

4071	5	Transurethral resection of vesical neck (male) (I.P.) (R.F.)
4072	5	Transurethral resection of bladder tumors (0.5-2.0 centimeters) (I.P.) (R.F.)
4073	5	Transurethral electrosection of prostate, including control of postoperative bleeding, complete (I.P.)
4074	4	partial (I.P.) (R.F.)
4075	4	2.0-5.0 centimeters (I.P.) (R.F.)
4076	5	greater than 5 centimeters (I.P.) (R.F.)
4078	5	Transurethral resection of posterior urethral valves (I.P.) (R.F.)
4079	4	Transurethral fulguration of posterior urethral valves (I.P.) (R.F.)
4083	4	Transurethral drainage of prostatic abscess (I.P.) (R.F.)
4085	3	Litholapaxy: crushing of calculus in bladder (I.P.)
4089	-	Not otherwise classified (I.C.)
		Urethra
		Incision
4090	3	Urethrotomy, external, anterior (I.P.)
4091	3	Perineal (I.P.)
4093	3	Meatotomy: cutting of meatus (I.P.)
4094	3	Urethrostomy: drainage by fistulization (I.P.)
4095	3	Drainage of periurethral abscess
4097	4	Drainage of perineal urinary extravasation (I.C.)
		Excision
4105	3	Excision or fulgeration of carcinoma of urethra (R.F.)
4106	3	Excision, bulbo-urethral gland (R.F.)

4107	3	Excision, diverticulum of urethra (I.P.)
4115	3	Excision, urethral polyps (R.F.)
4116	3	Excision or fulgeration of urethral caruncle (I.P.)
		Repair
4122	3	Urethroplasty: plastic operation on urethra (I.P.)
4127	3	Berry operation for urinary incontinence following perineal prostatectomy
4128	-	Heineke-Mikulicz procedure on external urethral meatus for stenosis
4130	3	Urethrorrhaphy: suture of urethral wound or injury (I.P.) (R.F.)
4133	4	Closure of urethrostomy or fistula of urethra (I.P.)
4135	4	Fischmann suburethral myoplasty for urinary incontinence
4136	5	Other procedures for incontinence, with or without A-P repair (I.C.)
		Manipulation
4140	-	Dilation of urethral stricture by passage of sound
4148	-	Catheterization of urinary bladder (special contract only) (R.F.)
4149	-	Not otherwise classified (I.C.)
		MALE GENITAL SYSTEM
		Penis
		Incision
4150	3	Dorsal or lateral slit of prepuce (I.P.)
		Excision
4160	3	Biopsy of penis (I.P.)
4164	3	Local excision of lesion of penis

4165	4	Amputation of penis, partial
4166	4	complete
4167	6	radical, including regional lymph nodes
4172	3	Circumcision, under age six
4173	3	age six or over
		Repair
4190	3	Plastic operation of penis for hypospadias, straightening of chordee (R.F.)
4191	3	with transplantation of prepuce (R.F.)
4193	3	Urethroplasty, for hypospadias, peno scrotal (R.F.)
4194	-	Scroto-perineal (R.F.)
4196	4	for epispadias (R.F.)
4205	4	Plastic operation on penis for injury (I.C.)
4206	-	Plastic repair of penis for other than injury of hypospadias (I.C.)
		Destruction
4221	-	Excision or fulguration of warts (I.P.)
		Testis
		Incision or excision
4231	3	Biopsy of testis, unilateral (I.P.)
4232	3	bilateral (R.F.)
4235	3	Orchiectomy, simple, unilateral
4236	3	bilateral
4237	6	radical, for tumor, with retroperitoneal gland dissection, unilateral
4238	6	radical, bilateral (R.F.)

4243	4	with inguinal exploration (R.F.)
4246	3	Excision, appendix testis
		Repair
4250	3	Reduction of torsion of testis by surgical means
4252	4	Orchiopexy, with attachment of testis to thigh (Torek), with or without hernia repair, unilateral
4253	4	bilateral (R.F.)
4254	3	with detachment of testis from thigh, second stage
		Epididymis
		Incision
4270	3	Drainage of abscess of epididymis, testis, and/or scrotal space
		Excision
4280	3	Biopsy of epididymis (I.P.)
4284	3	Excision of spermatocele, without epididymectomy (I.P.)
4285	3	Epididymectomy, unilateral (I.P.)
4286	3	bilateral (I.P.)
		Repair
4290	3	Epididymovasostomy: anastomosis of epididymis to vas deferens, unilateral (I.P.)
4291	3	bilateral (I.P.)
		Tunica Vaginalis
		Incision or excision
4300	-	Puncture aspiration of hydrocele
4303	4	Excision, hydrocele, unilateral
4304	4	bilateral

Scrotum

Incision

4310	3	Drainage of scrotal abscess
4313	3	Removal of foreign body in scrotum
4316	3	Exploration of scrotum

Excision

4320	3	Resection of scrotum (I.C.)
4321	-	Local excision of lesion of scrotum

Repair

4330	3	Scrotoplasty: plastic operation of scrotum (I.C.)

Vas Deferens

Excision

4351	3	Vasectomy, therapeutic only, not for sterilization, complete or partial, unilateral or bilateral
4370	3	Vasectomy or ligation of vas for sterilization, for persons aged 21 or older (Consent for Sterilization Form (CS-21) required)
4372	3	Vasectomy or ligation of vas for sterilization, for persons aged 18 through 20 years (Consent for Sterilization Form (CS-18) required)

Repair

4373	-	Vaso-vasostomy, reversal operation, unilateral
4374	-	bilateral

Spermatic Cord

Excision

4380	4	Excision, hydrocele of spermatic cord, unilateral
4381	4	bilateral

4385	4	Excision, varicocele, unilateral
4386	4	bilateral (R.F)

Seminal Vesicles

Incision or excision

4400	3	Vesiculotomy, unilateral
4401	3	bilateral (R.F.)
4403	3	Vesiculectomy, unilateral (I.P.)
4404	3	bilateral (R.F.)

Prostate

Incision

4420	4	Biopsy of prostate, needle (I.P.)
4421	4	open, perineal (I.P.)
4425	4	Prostatotomy: external drainage of prostatic abscess
4427	4	Prostatiolithotomy: removal of prostatic calculus (I.P.)

Excision (for TUR of prostate, see Service Codes 4073 and 4074)

4440	6	Prostatectomy, perineal, subtotal
4441	6	radical
4442	5	Prostatectomy, suprapubic, one or two stages
4443	5	retropubic, one or two stages
4449	-	Not otherwise classified (I.C.)

FEMALE GENITAL SYSTEM

Perineum

Incision

4450	3	Perineotomy, with exploration, drainage of abscess, etc.

4454	3	Episiotomy, nonobstetrical (I.P.)
		Excision or repair
4465	3	Episiorrhaphy: suture of recent injury of vulva (nonobstetrical) (R.F.)
4466	3	Episioperineorrhaphy: suture of recent injury of vulva and perineum (nonobstetrical)
4470	3	Perineoplasty: plastic repair of perineum (I.P.)
4473	3	Repair of perineum and third-degree laceration of the rectum (excluding postpartum repair) (I.P.)
4474	4	Perineorrhaphy: suture of recent injury of perineum (nonobstetrical) (R.F.)
4475	3	Closure of perineal fistula (I.P.)
4478	3	Episioplasty: plastic repair of vulva (R.F.)
		Vulva and Introitus
		Incision
4480	3	Incision and drainage of abscess of vulva
4485	3	Incision and drainage of Skene's gland abscess
4486	3	Incision and drainage of Bartholin's gland abscess, unilateral
4487	-	bilateral (R.F.)
		Excision
4490	3	Biopsy of vulva (I.P.)
4491	4	Vulvectomy, partial
4492	6	complete
4494	6	radical, including lymph nodes
4504	3	Hymenectomy, complicated for hematocolpos (R.F.)
4505	3	Excision, hymen, hymenectomy (I.P.)

4506	3	Incision, hymen, hymenotomy (I.P.)
4507	3	Excision, cautery destruction of Bartholin's gland or cyst, unilateral
4508	3	bilateral (R.F.)
4509	3	Excision or fulguration of Skene's glands (I.P.)
		Destruction
4537	3	Local excision of lesion of external female genital organ (R.F.)
		Vagina
		Incision
4540	3	Colpotomy, with exploration or drainage of pelvic abscess
4541	4	Needle colpotomy
4542	3	Culdotomy, with definitive therapy (ovarian cyst, ectopic, etc.) (R.F.)
4545	3	Puncture and aspiration of cul-de-sac
		Excision
4550	3	Biopsy of vagina (I.P.)
4551	5	Colpectomy or colpoclesis, complete (complete obliteration of vagina)
4552	4	partial (Laforte)
4554	3	Excision, vaginal cyst (I.P.)
4555	3	Excision, vaginal septum (I.P.) (R.F.)
4556	3	Excision, septate vagina, introitus to cervical canal
		Repair
4570	3	Colporrhaphy: suture of recent injury of vagina (nonobstetrical) (R.F.)
4571	4	Colpoperineorrhaphy: suture of recent injury of vagina and perineum (nonobstetrical) (R.F.)

4572	3	Plastic repair of female urethra for prolapse of mucosa (I.P.)
4573	3	Plastic operation of urethral sphincter (female) (Kelly, Kennedy)
4574	3	Repair of urethrocele (female) (I.P.)
4575	3	Colpoplasty: anterior vaginal wall, repair of cystocele (I.P.)
4576	3	with repair of urethrocele (I.P.)
4577	3	posterior vaginal wall, repair of rectocele (I.P.)
4578	3	Colpoperineoplasty, posterior vaginal wall, repair of rectocele and perineoplasty: pelvic floor repair
4580	3	Anterior and posterior vaginal walls, repair of cystocele, rectocele, and perineoplasty
4583	3	with repair of urethrocele
4584	3	Repair of enterocele, any approach, with or without associated related procedures
4586	3	Colpopexy, abdominal (vaginal suspension)
4587	3	Reconstruction of congenital deformities of vagina, including vaginal artesia and septate vagina (I.C.)
4593	4	Closure of urethrovaginal fistula (I.P.) (see Service Code 3436 for closure of rectovaginal fistula)
		Manipulation
4600	3	Dilation of vagina under anesthesia (I.P.)
		Endoscopy
4610	3	Culdoscopy (I.P.)
4612	3	Laparoscopy (diagnostic)
		Cervix Uteri
4618	3	Colposcopy, with biopsy of cervix uteri (for evaluation of early cervical neoplasia)

4619	3	Colposcopy (for evaluation of early cervical neoplasia)
		Excision
4620	3	Biopsy of cervix or local excision of lesion of cervix (I.P.)
4622	3	Conization (I.P.)
4623	3	Cauterization of cervix (thermo-, electro-, cryo-)
4624	4	Trachelectomy: cervicectomy; amputation of cervix (I.P.)
4625	6	Removal of cervical stump, abdominal
4627	-	vaginal
4628	6	Removal of cervical stump, vaginal, with or without pelvic floor repair, enterocele, urethrocele, or cystocele
4629	3	Modified Sturmodorf on cervix
4632	3	Partial excision of cervix (I.P.)
4633	-	Local excision of lesion of cervix, in conjunction with dilation and curettage (I.P.)
		Repair
4653	4	Trachelorrhaphy: suture of recent injury or laceration of cervix (nonobstetrical) (R.F.)
4658	3	Tracheloplasty: plastic repair of cervix (Emmett)
		Manipulation
4660	3	Dilation of cervix, instrumental (I.P.)
4668	3	Manual replacement of retroverted uterus (inpatient only)
		Corpus Uteri
4669	3	Pelvic examination under anesthesia (I.P.)

		Incision
4671	6	Hysterotomy, nonobstetrical, abdominal approach (R.F.)
4679	-	Incision of uterus (not otherwise classified) (R.F.)
4680	3	Endometrial biopsy (I.P.)
4681	3	Dilation and curettage of uterus (I.P.)
4682	6	Hysteromyomectomy: myomectomy, excision of fibroid tumor of uterus (I.P.)
4685	6	Panhysterectomy: total hysterectomy (corpus and cervix) (S.O.) (Hysterectomy Information Form (HI-1) required)
4687	6	Fundectomy: uterine, excision of fundus of uterus (S.O.)
4689	6	Panhysterectomy, with Marchetti suspension (S.O.) (Hysterectomy Information Form (HI-1) required)
4691	6	Complete hysterectomy, with partial pelvic lymphadenectomy (S.O.) (Hysterectomy Information Form (HI-1) required)
4692	8	Radical hysterectomy for cancer, Werthein, with complete radical pelvic lymphadenectomy (S.O.) (Hysterectomy Information Form (HI-1) required)
4693	10	Complete pelvic exenteration
4696	6	Vaginal hysterectomy, with or without pelvic floor repair, enterocele, urethrocele, or cystocele (S.O.) (Hysterectomy Information Form (HI-1) required)
4701	3	Dilation and curettage for removal of uterine polyps
		Introduction
4711	3	Insertion of radioactive substance into cervix, uterus, or both, with or without biopsy or dilation and curettage
4713	-	Insufflation of the tubes (CO_2) (R.F.)
4714	-	Hydrotubation of the tubes
4715	-	Injection of hysterosalpingogram

4716	-	Transabdominal pneumogynecogram
		Repair
4723	6	Hysterosalpingostomy: anastomosis of tubes to uterus (I.P.) (R.F.)
4724	6	Hysterorrhaphy: suture of ruptured uterus (nonobstetrical) (I.P.)
4727	6	Hysteroplasty: repair of uterine anomaly, Strassman (I.P.) (R.F.)
4728	6	Huntington operation for inverted uterus (I.P.)
4733	6	Manchester operation, with vaginal sling procedure for incontinence (I.P.)
4734	6	Manchester operation, with Kennedy repair of urethral sphincter (I.P.)
4735	6	Vaginal hysterectomy, with Kennedy repair of urethral sphincter (S.O.) (I.P.) (Hysterectomy Information Form (HI-1) required)
4739	-	Insertion of IUD (the cost of the IUD should be billed under Service Code 160011 at the physician's acquisition cost)
		Oviduct
		Incision
4740	5	Transection or ligation of Fallopian tubes, abdominal or vaginal approach, for persons aged 21 or older (Consent for Sterilization Form (CS-21) required)
4742	5	Transection or ligation of Fallopian tubes by laparoscopy, for persons aged 21 or older (Consent for Sterilization Form (CS-21) required)
4744	5	Transection or ligation of Fallopian tubes, abdominal or vaginal approach, for persons aged 18 through 20 (Consent for Sterilization Form (CS-18) required)
4745	5	Transection or ligation of Fallopian tubes by laparoscopy, for persons aged 18 through 20 (Consent for Sterilization Form (CS-18) required)

Excision

4750	5	Salpingectomy, unilateral or bilateral (I.P.)
4753	6	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (I.P.)
4755	6	Salpingoplasty for sterility, unilateral or bilateral (I.P.) (R.F.)
4756	5	Readmission for removal of prosthesis by laparotomy (R.F.)

Ovary

Incision

4771	6	Drainage of ovarian cyst, unilateral or bilateral (I.P.)

Excision

4780	6	Excision of ovarian cyst, unilateral or bilateral
4783	6	Oophorectomy, partial, unilateral or bilateral (I.P.) (R.F.)
4785	6	Complete oophorectomy, unilateral or bilateral (I.P.)

Repair

4790	6	Oophoroplasty, unilateral or bilateral (I.P.)
4793	6	Oophoropexy, unilateral or bilateral (I.P.) (R.F.)
4799	-	Not otherwise classified (I.C.)

Maternity Care and Delivery

Incision

4800	-	Transperitoneal amniotomy, initial
4801	-	subsequent
4802	-	Amniocentesis

Excision

4810	6	Abdominal hysterotomy for mole or previable fetus
4811	3	Dilation and curettage for hydatidiform mole

4814	6	Removal of extrauterine embryo (ectopic pregnancy) by laparotomy
4818	3	Dilation and curettage for postpartum bleeding
		Repair
4832	3	Suture of incompetent cervix, patient pregnant
4833	3	patient not pregnant
		Delivery, antepartum and postpartum care
4842	4	Pelvic delivery (exclusive of prepartum and postpartum care)
		Caesarean section
4860	6	Low cervical (low uterine segment) Caesarean section (exclusive of prepartum and postpartum care)
4863	6	Classic Caesarean section (exclusive of prepartum and postpartum care)
4866	6	Extraperitoneal Caesarean section (Waters, Latzko)
4870	6	Caesarean section and hysterectomy (Porro)
4873	6	Caesarean section, with total hysterectomy (not Porro)
4875	6	Vaginal Caesarean section
4879	-	Not otherwise classified (I.C.)
		Abortion
4882	3	Induced abortion, first trimester (Certification for Payable Abortion (CPA-2) form required)
4884	6	Induced abortion, second trimester, in hospital only (Certification for Payable Abortion (CPA-2) form required)
4885	6	Induced abortion, third trimester, in hospital only (Certification for Payable Abortion (CPA-2) form required)
4889	3	Spontaneous abortion (miscarriage), with dilation and curettage (no report required)

ENDOCRINE SYSTEM

Thyroid Gland

Incision

4900	3	Incision and drainage of thyroglossal cyst (infected)
4901	6	Thyroidotomy: with drainage of abscess or cyst (R.F.)
4918	6	Open excision for biopsy of thyroid

Excision

4920	-	Needle biopsy of thyroid
4922	6	Local excision of small cyst or adenoma thyroid
4923	6	Excision of thyroid isthmus (R.F.)
4924	6	Excision of aberrant thyroid or lesion thereof (R.F.)
4926	6	Thyroidectomy, total or complete
4927	6	subtotal or partial
4928	6	total or subtotal for malignancy, with radical neck dissection
4933	13	Sternotomy and excision of substernal thyroid (R.F.)
4937	6	Excision of thyroid remnant
4938	6	Excision of thyroglossal duct, cyst, or sinus

Parathyroid, Thymus, Pituitary, Pineal, and Adrenal Glands and Carotid Body

Excision

4970	6	Parathyroidectomy or exploration for parathyroid
4972	6	Thymectomy
4975	11	Adrenalectomy, unilateral
4977	11	bilateral, one stage
4985	6	Pinealectomy

4999	-	Not otherwise classified (I.C.)
		NERVOUS SYSTEM
		Skull, Meninges, and Brain
		Incision
5000	4	Subdural tap, under age two
5002	4	age two or over (I.P.)
5007	4	Ventricular tap (I.P.)
5014	7	Ventriculography (I.P.)
5017	3	Cisternal puncture
5020	7	Trephination (or burr holes) exploratory, unilateral
5021	7	bilateral
5025	11	Drainage of brain abscess, primary tapping
5026	4	subsequent tapping in operating room
5030	5	Transphenoidal exploration or biopsy of brain
		Craniectomy or bone flap craniotomy
5043	11	Drainage of subdural, epidural, or subarachnoid space for abscess or hematoma, cranial
5044	11	spinal
5048	11	Decompression, orbital, unilateral
5049	11	bilateral
5050	11	subtemporal
5052	11	suboccipital
5054	8	Tractotomy (medulla, mesencephalon)
5055	11	Frontal lobotomy, unilateral by craniotomy
5056	11	bilateral by craniotomy

5057	11	Removal of foreign body in brain (I.C.)
		Excision or destruction, trephine craniectomy, or bone flap craniotomy
5061	11	Excision of brain cyst, neoplasm, or abscess
5063	11	Osteoplastic craniotomy (other than operation for brain tumor)
5064	11	Reopening of craniotomy for exploration, hemorrhage, etc. (R.F.)
5066	11	Osteoplastic craniotomy for intracranial vascular malformation
5069	11	Excision of portion of skull for osteomyelitis
5070	11	Excision of cortical scar for epilepsy
5076	11	Excision of lobe of brain
5078	11	Excision of brain tissue, topectomy
5079	11	Re-excision of brain tissue, cyst, tumor, etc. (I.C.)
5080	11	Excision of choroid plexus
5081	11	Intracranial operation for removal of pituitary tumor
5082	5	Transphenoidal exploration or excision of pituitary tumor
5085	9	Chemopalledectomy, one or more stages
5087	11	Stereotaxic procedure for pituitary conditions other than tumor
5089	-	Stereotaxic lesion for other than cingulotomy globus pallidus and pituitary
		Introduction
5090	3	Encephalography (I.P.)
5095	3	Intrathecal fluorescein dye test
5096	4	Implantation of electrodes for intractable pain

5097	3	Placement of radio frequency receiver
		Repair
5101	11	Skull fracture, compound, with operation without dural penetration
5102	11	depressed, with operation, including debridement of brain and repair of dura
5103	11	Repair of cerebrospinal fluid leak, cranial
5104	5	nasal approach
5105	11	mastoid approach
5106	11	Repair of encephalocele
5107	11	Cranioplasty: plastic operation on skull, with bone graft, or metal or plastic plate
5109	11	with autogenous bone from rib or iliac (two surgeons, each)
5111	11	Craniectomy for parasagittal craniosynostosis
5113	11	Ventriculocisternostomy by catheter, Torkildsen's operation with plastic tube
5115	11	Ventriculo-auricular shunt
5117	11	Revision of V-A shunt, different hospitalizations
5119	7	Removal of shunt tube and/or valve
5120	7	Revision of shunt, same admission
5125	11	Marsupialization of lesion (cyst, abscess)
		Suture
5132	11	Graft of dura
5139	-	Not otherwise classified (I.C.)

Spine and Spinal Cord

Incision

5140	6	Exploration of spinal region, extradural
5141	7	Decompression of spinal cord (by removal of hematoma bone fragments)
5142	6	Cervical
5143	7	Excision of neural arch and nerve, exploration for spondylolisthesis
5145	7	with fusion
5147	8	Rhizotomy: division or transection of nerve roots
5150	8	Chordotomy: tractotomy or division or transection of nerve tracts in cord, cervical or dorsal
5153	8	Percutaneous cervical chordotomy by electrofrequency and stereotactic approach
5154	8	Drainage of spinal cord (cyst)
5155	3	Simple spinal puncture (I.P.)
5156	3	Lumbar puncture, spinal tap, first (I.P.)
5158	-	Drainage of lateral or sigmoid sinus phlebitis or thrombosis
5160	8	Exposure and/or exploration of lumbar or sacral spine through anterior presacral approach

Excision

5170	11	Laminectomy, cervical or thoracic (S.O.)
5171	11	lumbar (S.O.)
5173	11	Hemilaminectomy, cervical (S.O.)
5175	11	dorsal (S.O.)
5176	11	lumbar (S.O.)

5178	7	Laminotomy, decompressive or exploratory (S.O.)
5180	11	Excision of meningeal tumor, cyst, or aneurysm
5181	11	Marsupialization of lesion of meninges (cyst, abscess)
5182	7	Excision of lesion of spinal cord (neoplasm, cyst)
5183	7	Chemonucleulysis
5184	7	Excision of disc
5185	7	Excision of intervertebral disc, with spinal fusion (two surgeons, each)
5186	4	Opening, testing, and closure
5187	-	Opening and closure without testing
5188	-	Testing only
		Introduction
5190	3	Injection of neurocidal agent into spine, subarachnoid (I.C.)
5193	3	Myelography (I.P.)
5197	3	Discography only
5198	-	Complete procedure
		Repair
5200	11	Repair of meningocele (spina bifida)
5203	11	Repair of meningomyelocele
5205	11	Subarachnoid ureterostomy or peritoneostomy
5207	11	with repair of meningocele
5208	11	Revision of subarachnoid ureterostomy or peritoneostomy (I.C.)
5209	-	Not otherwise classified (I.C.)

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System

Incision, transection, or avulsion of nerve

5210	4	Neurexeresis, avulsion of supraorbital nerve
5211	4	avulsion of infraorbital nerve
5215	5	Transection of occipital nerve
5216	4	Transection of phrenic nerve, phrenicectomy
5218	11	Vagotomy or vagectomy, transthoracic (R.F.)
5219	6	Transection of vagus nerve; vagotomy; in abdomen (I.P.)
5222	5	Differential section of trigeminal nerve, extradural (R.F.)
5224	11	Transection of trigeminal and glossopharyngeal nerve
5225	6	Exploration of brachial plexus (I.P.)
5226	11	Retrogasserian neurotomy: transection of sensory root, trigeminal nerve, transtemporal
5227	11	posterior fossa
5228	11	intramedullary
5229	11	Gasserian ganglionectomy (I.C.)
5230	3	Obturator neurectomy, unilateral
5231	3	bilateral
5235	5	Transection of spinal nerves
5236	-	Transection of other nerves (R.F.)
5239	4	Neurexeresis: avulsion of phrenic nerve, phrenicoexeresis
5241	3	Excision of peripheral neuroma of digit
5242	3	other, superficial
5243	3	deep

5247	3	Stoefel's neurectomy, unilateral
5248	3	bilateral
		Sympathectomy
5250	6	Cervical, unilateral
5251	6	bilateral
5260	6	Lumbar, unilateral
5261	6	bilateral
5265	8	Splanchnicectomy, unilateral
5266	10	bilateral
		(A nerve block with alcohol commands an additional fee (see Service Code 5348).)
		Introduction: nerve block
5280	-	Trigeminal nerve, initial and subsequent
		Somatic
5281	-	Infraorbital, supraorbital, or supratrochlear nerve, once only
5282	-	Occipital nerve, initial and subsequent
5283	-	Inferior dental nerve, initial and subsequent
5284	-	Phrenic nerve, initial and subsequent
5286	-	Intercostal nerves, initial and subsequent
5290	-	Ilioinguinal and iliohypogastric nerves, initial and subsequent
5291	-	Internal pudic nerve, initial and subsequent
5294	-	Lumbar, sacral, and coccygeal nerves, initial and subsequent
5295	-	Paravertebral block, lumbar or thoracic, initial and subsequent

5296	-	Sciatic nerve, initial and subsequent
5302	-	Nerve block for postspinal headache
5303	-	Epidural block
5305	-	Facial nerve
5306	-	Vagus nerve (R.F.)
5308	-	Spinal accessory nerve (R.F.)
5310	-	Carotid sinus, once only
5311	-	Suprascapular nerve, maximum
5315	-	Splanchnic nerves, initial and subsequent
5318	-	Local infiltration with anesthetic agent, initial and subsequent
		Sympathetic
5320	-	Stellate ganglion, initial and subsequent
5321	-	Gasserian ganglion, initial and subsequent
5322	-	Cervical and thoracic sympathetic ganglia, initial and subsequent
5323	-	Lumbar sympathetic ganglia, initial and subsequent
5325	-	Continuous lumbar sympathetic block, once only
		Neurolytic agent
5336	-	Injection, trigeminal ganglion with alcohol (R.F.)
5348	-	Injection of alcohol as adjunct to nerve blocks
5349	-	Not otherwise classified (I.C.)
		Neurorrhaphy--Suture of Nerve
		Repair
5351	3	Digital nerve, within digits, suture, lysis, or freeing from scar

5353	3	Neuroplasty; major nerve, upper or lower arm or leg, old injury, including scar excision, local advancements, etc. (R.F.)
5354	3	recent injury or transplant (R.F.)
5355	3	sensory nerves, hand or foot, excluding digits, suture, lysis, or freeing from scar, or transfer (R.F.)
5356	5	motor branch, thenar median nerve, new or old injury
5357	5	motor branch, ulnar nerve, new or old injury
5358	3	grafts or other unlisted procedures, major or minor nerves (I.C.)
5362	4	Brachial plexus or lumbar (I.C.)
5365	-	Neuro-anastomosis, spinal, accessory-facial, hypoglossal-facial
		Neuroplasty
5388	3	Lysis or freeing from scar of intact nerve
		Destruction
5390	4	Phrenemphraxis, crushing of phrenic nerve
5391	4	crushing of other nerves
5399	-	Not otherwise classified (I.C.)
		EYE
		Eyeball
		Incision
5400	4	Enucleation of eyeball (bulb or globe)
5401	4	with movable integrated implant, primary
5402	4	secondary
5403	4	with implantation of prosthesis
5406	4	Evisceration of eyeball

5407	4	with implantation of scleral shell
5408	4	Removal of implant
5409	4	Revision of eye socket, with or without reinsertion of implant
5415	3	Eye examination, child, under general anesthesia
		Repair
5420	4	Suture of eyeball for wound or injury (R.F.)
		Cornea
		Incision
5430	4	Keratotomy, any type
5431	4	Paracentesis of cornea (keratocentesis)
5433	4	Removal of foreign body from surface of cornea
5434	4	Corneal section, with or without iridectomy, with irrigation
5435	4	Removal of foreign body embedded in cornea (R.F.)
5437	-	with magnet
		Excision
5440	4	Partial keratectomy (R.F.)
5441	4	Keratectomy, complete corneal stripping
5443	4	Pterygium, primary
5444	4	McReynolds, transplant of pterygium (R.F.)
5445	4	Pterygium, secondary
5446	4	Curettage and cauterization of corneal ulcer
		Introduction
5450	4	Tattoo of cornea, mechanical or chemical
5455	4	Iontophoresis of corneal ulcer

Repair

5460	6	Keratoplasty: corneal transplant lamellar
5461	6	partial or complete, penetrating
5465	6	Suture of perforating wound of cornea

Anterior Chamber

Incision

5470	-	Aspiration of anterior chamber
5473	4	Goniotomy, primary
5474	4	secondary
5476	6	with removal of foreign body from anterior chamber, with or without magnet
5477	6	removal of intraocular foreign body, with magnet, without operative incision

Introduction

5483	4	Air injected into anterior chamber, without irrigation (R.F.)
5484	4	Air injection, with or without irrigation, for glaucoma (R.F.)
5485	6	Chamber deepening for glaucoma (R.F.)

Sclera

Incision

5490	6	Sclerotomy, operative incision, with removal of intraocular foreign body, posteriorly, magnetic
5491	6	nonmagnetic
5493	4	Sclerotomy, posterior, paracentesis
5494	6	Reattachment of choroid with sclerotomy (R.F.)
5495	6	Sclerostomy, fistulization (R.F.)

Excision

5500	6	Sclerectomy for glaucoma with scissors, punch or trephination (Lagrange, Holth, Elliott)
5505	6	Scleral resection, full thickness
5506	6	Lamellar
5508	6	Suture of sclera for wound or injury (R.F.)

Iris and Ciliary Body

Incision

5510	6	Iridotomy
5512	-	Injection of alcohol into ciliary ganglion for absolute glaucoma (R.F.)
5513	6	With transfixion of iris (iris bombe)
5515	6	Corelysis, lysis of anterior synechia

Excision

5520	6	Excision, lesion of iris
5523	6	Complete iridectomy, optical iridectomy, preliminary iridectomy
5525	6	Iridotasis (iridencleisis): stretching of iris (I.P.)

Repair

5530	6	Iridodialysis
5535	6	Repair of prolapsed iris, with suture of perforated sclera or cornea

Choroid

Excision

5540	-	Biopsy of choroid (I.P.) (R.F.)
5545	4	Choroidal tap (R.F.)

		Destruction
5550	6	Diathermy of the ciliary body, cyclodiathermy
5555	6	Cyclodialysis
		Crystalline Lens
		Incision
5560	6	Discission, needling of lens, primary
5561	4	secondary
5562	6	Excision, pupillary membrane, simple (R.F.)
5563	6	complicated (R.F.)
5564	8	Removal of dislocated lens
5566	6	Capsulotomy for cataract (R.F.)
		Excision
5570	8	Extraction of lens, intracapsular or extracapsular, unilateral
5571	8	bilateral (I.C.)
5573	8	Extraction of lens, intracapsular or extracapsular, with cyclodialysis, filtering operation, or sclerotomy, unilateral (R.F.)

5574	8	bilateral (I.C.)
5575	8	Extraction of lens, with or without iridectomy micro-surgery, unilateral (R.F.)
5576	8	bilateral (I.C.)

Vitreous

Introduction or incision

5580	6	Transplant of vitreous
5581	4	Aspiration of vitreous (R.F.)
5582	-	Comprehensive vitreoretinal study, each eye

Retina

Repair

5590	6	Reattachment of retina, electrocoagulation, initial
5591	6	subsequent
5592	6	Scleral buckling, primary
5593	6	secondary
5595	6	Removal of encircling tube (R.F.)
5598	6	Cryopexy, primary
5599	6	secondary
5601	4	Photocoagulation, primary
5602	6	secondary
5605	6	Reattachment of retina and choroid, initial
5606	-	Retinal angiography (includes surgical introduction and diagnostic photography), each eye
5607	-	Retinal drawing

Extraocular Muscles

Incision, excision, and repair

5620	5	Myotomy, tenotomy, recession, resection advancement, or shortening of ocular muscles for strabismus, one or more stages, unilateral
5621	5	bilateral
5622	5	One muscle, initial
5623	5	subsequent
5625	5	Muscle transplant

Orbit

Incision

5630	6	Orbitotomy, with exploration (R.F.)
5631	6	with drainage of intraorbital abscess (R.F.)
5632	6	with removal of intraorbital foreign body (R.F.)
5635	6	Decompression of orbit, antral approach (R.F.)
5636	6	Kronlein approach (R.F.)
5637	6	Exenteration or evisceration of orbital contents
5639	6	with skin graft
5640	6	Excision, lesion of orbit, benign or malignant (R.F.)
5641	6	Removal of orbital tumor, anterior approach

Excision

5650	4	Biopsy of orbit (R.F.)
5655	4	Plastic repair of orbit (R.F.)

Introduction

5660	-	Retrobulbar injection, priscoline, procaine, etc. (R.F.)
5661	-	Orbital injection of alcohol for hemorrhagic glaucoma or intractable pain

Eyelids

Repair

5670	4	Blepharotomy, with drainage of abscess of eyelids
5671	4	with drainage of meibomian gland, hordeolum (sty)
5672	4	Canthorrhaphy, suture of palpebral fissure of canthus (R.F.)
5673	4	Canthoplasty, external and/or plastic repair
5674	4	internal, for repair of epicanthus or evulsed canthal ligament
5675	5	Levator resection for ptosis (P.A.)
5676	4	Excision, malignant lesion of eyelid (I.C.)
5677	4	Excision, xanthoma, single
5678	4	multiple

Excision

5680	4	Meibomian glands (chalazion), single
5681	4	multiple
5683	4	Excision, benign lesion of the eyelid, single
5684	4	multiple
5688	4	Excision or reposition of cilia base
5689	4	Blepharectomy, blepharorrhaphy, and blepharoplasty: plastic repair of eyelid, with graft, any type (P.A.) (R.F.)
5687	4	without graft (P.A.) (R.F.)

Repair

5690	4	Plastic operation for ptosis, unilateral (P.A.) (R.F.)
5691	4	bilateral (P.A.) (R.F.)
5692	4	Suture sling repair for ptosis, unilateral (P.A.)

5693	4	bilateral (P.A.) (R.F.)
5694	4	Cautery puncture for entropian or ectropian
5696	4	Tarsorrhaphy or tarsoplasty, suture or repair of tarsal cartilage (R.F.)
5697	4	Repair of entropion, Wheeler or other type (R.F.)
5698	4	Excision blepharochalasis, with plastic repair
		Conjunctiva
		Incision
5700	-	Removal of foreign body from surface of conjunctiva
5710	4	Biopsy of conjunctiva (I.P.)
5712	4	Excision of lesion of conjunctiva, cyst (R.F.)
5714	4	Peritectomy, peritomy, excision of pannus (R.F.)
5715	4	Excision, lesion of conjunctiva, epithelial (R.F.)
5716	4	nevus
		Introduction
5720	-	Retrobulbar or subconjunctival injection of depomedrol (R.F.)
		Repair
5730	4	Suture of conjunctiva (R.F.)
5731	4	Free graft of conjunctiva
5732	4	Free graft of mucous membrane
5735	4	Flap operation for corneal ulcer
5736	6	Flap operation, flapping of conjunctiva for perforating injuries, or laceration or operative wound
5737	4	Repair of symblepharon without graft (R.F.)

Lacrimal Tract

Incision

5740	4	Drainage of lacrimal gland (abscess)
5741	4	Slitting of lacrimal papillae (R.F.)
5742	4	Slitting of punctum with curetting of the canaliculus for stenosis or dacryocystitis
5743	4	Drainage of lacrimal sacdacryocystotomy: dacryocystostomy

Excision

5750	4	Excision, lacrimal gland, dacryoadenectomy
5753	4	Excision, lacrimal sac, dacryocystectomy
5755	4	Excision, lacrimal gland tumor

Introduction

5760	4	Intubation of lacrimonasal duct under general anesthesia (R.F.)
5761	4	Catheterization of lacrimonasal duct, initial (I.P.)
5762	4	subsequent (R.F.)

Repair

5770	4	Plastic operation canaliculi
5773	4	Dacryocystorhinostomy, fistulization of lacrimal sac into nasal cavity, with or without anterior ethmoidectomy (Toti)
5777	4	Closure of punctum by cautery (I.P.)

Manipulation

5780	4	Dilation of punctum
5782	4	Probing of lacrimonasal duct
5783	4	under general anesthesia

5799	-	Not otherwise classified (I.C.)

EAR

External Ear

Incision

5800	4	Drainage of abscess of auricle
5802	4	Drainage of hematoma of auricle (R.F.)
5803	4	Drainage of abscess of external auditory canal
5804	4	Drainage of furuncle of ear (R.F.)

Excision

5810	4	Biopsy of ear (I.P.)
5811	4	Local excision of lesion of ear (R.F.)
5812	4	with plastic closure (R.F.)
5813	4	Complete excision of ear: amputation of ear
5814	4	Excision of exostosis of external auditory canal (R.F.)
5815	6	Radical excision of malignant lesion of external auditory canal (R.F.)
5816	6	with neck dissection (R.F.)

Endoscopy

5830	4	Otoscopy, with removal of foreign body in external auditory canal
5831	4	under general anesthesia
5834	-	Cauterization of perforated eardrum (R.F.)

Repair

5840	4	Correction of lop ears, unilateral (P.A.)
5841	4	bilateral (P.A.)
5842	4	Otoplasty, plastic operation on ear (P.A.) (I.C.)

5843	4	Reconstruction of external auditory canal for congenital atresia, with flaps and/or graft (I.C.)
5845	4	Reconstruction of ear, with graft of skin or cartilage (R.F.)
5847	4	Suture of wound or injury of ear (R.F.)

Middle Ear

Incision

5870	4	Myringotomy, tympanotomy, plicotomy, unilateral
5871	4	bilateral
5872	4	Myringotomy, with insertion of arrow tube, unilateral
5873	4	bilateral
5876	4	Elevation of tympanomeatal flap, with exploration and insertion of drainage tubes, unilateral
5877	4	bilateral
5878	4	Tympanotomy, with exposure of middle ear contents
5880	5	Postaural tympanotomy and repair of ear canal
5881	-	Myringotomy, office, without anesthesia, unilateral
5882	-	bilateral

Excision

5890	5	Mastoidectomy, antrotomy
5892	5	complete exenteration of air cells
5894	5	Radical mastoidectomy, unilateral
5895	5	bilateral (R.F.)
5898	5	Exenteration of air cells of petrous pyramid, including radical mastoidectomy
5900	4	Removal of middle ear polyp by snare
5905	4	Ossiculectomy (R.F.)

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5906	5	Reconstruction of ossicular chain (R.F.)
5907	5	Reconstruction of ossicular chain by cartilaginous graft (R.F.)
5910	5	Interposition operation (R.F.)
5911	5	with antrotomy (R.F.)
		Repair
5920	5	Revision of radical mastoid cavity (I.C.)
5921	4	Tympanoplasty, type V, for congenital malformation of middle ear canal
5924	5	Myringoplasty
5926	4	Tympanoplasty, type I
5927	4	with mastoid antrotomy
5928	4	Tympanoplasty, type II
5929	4	with mastoid antrotomy
5930	4	Tympanoplasty, type II, III, or IV, with mastoidectomy
5931	4	Tympanoplasty, type III or IV
5932	4	with mastoid antrotomy
5933	4	Stapes mobilization
5935	4	Stapedectomy, with prosthesis
5936	5	Revision of stapedectomy (I.C.)
5937	5	Musculoplasty and radical mastoidectomy (R.F.)
		Suture
5950	4	Closure of fistula, mastoid (R.F.)
5954	11	Decompression of facial nerve, mastoid approach (R.F.)

Internal Ear

Incision

5970	5	Labyrinthotomy (R.F.)
5972	6	Fenestration of semicircular canals
5975	6	Revision of fenestration operation (R.F.)
5985	4	Anterior or posterior crurotomy
5998	-	Ultrasonic treatment (irradiation) for Menieres disease (R.F.)

Excision

5990	6	Labyrinthectomy
5989	-	Not otherwise classified (I.C.)

REGULATORY AUTHORITY

106 CMR 433.000: M.G.L. c. 18, s. 10; M.G.L. c. 118E, s. 4.

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